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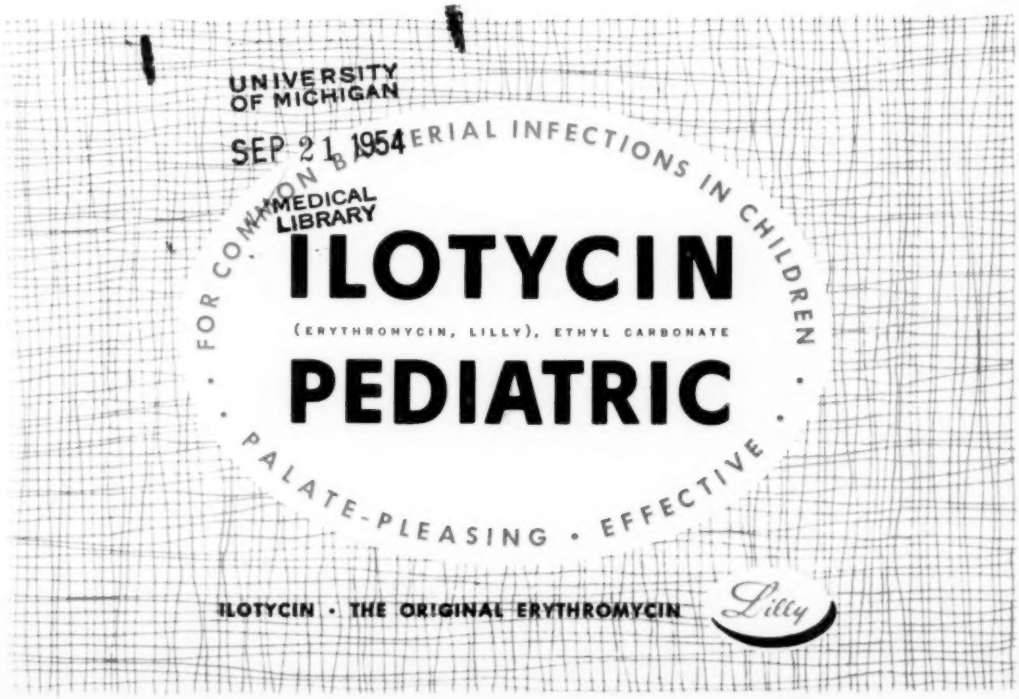

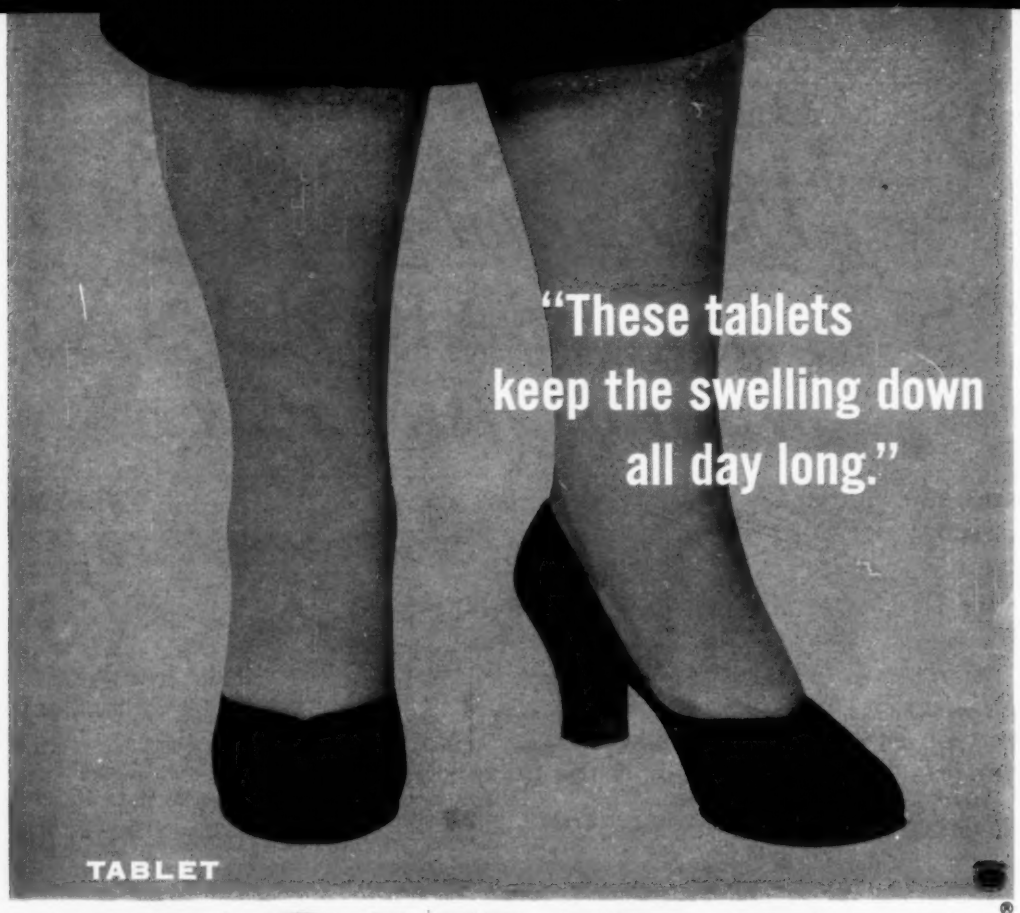

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A Doctor Examines His Profession

PRESIDENTIAL ADDRESS 1954

C. R. F. BAKER, M. D.
Sumter, S. C.

Some years ago the public placed the doctor on a pedestal, and made him a popular hero—the darling of the hour. The public looked up to and loved its doctors—those selfless men who gave their life's blood to serve their fellow man. Old Doctor Smith hadn't saved a thin dime in fifty years of practice, and wasn't it a shame his roof leaked and that poor dear Mrs. Smith was wearing a five year old coat bought in the first place from Sears-Roebuck? It was enough to make your blood boil to see that rich patient of his (a shady character who had made his pile by exploiting great numbers of the poor and ignorant of the town) ride around in a new Cadillac with his wife beside him draped in mink and wearing a three karat diamond ring to boot. Old Doctor was a saint on earth—God bless him—but too kindly to push collecting the pittance he charged, but never got.

Contemporary fiction, radio soap-opera, and the movies spent their all in polishing up the doctor's halo. Doctor heroes were sure-fire, and what doctors they were—only a little taller than the angels in skill, nobility of character, and physical endurance that assured their patients twenty-four hour service complete with toothpaste-ad smiles. They, every last one of them, looked like young Doctor Kildare (one novel had the saccharine title "Young Doctor Galahad") and they all had the medical genius of a Dr. Harvey Cushing or the genial, warm personality of a Buck Pressley. They never, never lost a patient or even bothered to send a bill. They were above and beyond the common run of men. So removed in spirit from ordinary humanity they seemed to have no crass details like grocery bills or insurance premiums or keeping three kids in college at the same time to agonize about. Medicine was praised, honored, even revered. "The beloved profession", some woman writer, her pen dipped in treacle, called it. Doctors were classed with ministers and teachers, and spoken of with genuine regret as over-worked, self-effacing, and underpaid! But what spiritual dividends a doctor reaped—what other profession offered such a chance for soul-satisfaction—for following the precepts of the beloved physician, St. Luke, and for dedicating one's earthly existence to the saving of lives and the alleviation of human suffering. The public truly believed that doctors spent their lives in the beautiful shadow of the Hippocratic oath, and took them to its heart with an awed and fanatical devotion. All honor to those wonderful men in white! "Let's encourage our son to study medicine. A doctor has such prestige." All the girls wanted either to marry Clark Gable or a doctor! Doctor worship was at its highest peak, and only a very few rugged individualists had the nerve to mutter, "Dr. X. charged me $175 for an appendix operation that took him 20 minutes to perform, the highway robber." Such heresy was squelched by the loud defending chorus of grateful patients, "He snatched you from the very jaws of death! Pay and be thankful." Our patients were our biggest press agents and good-will ambassadors, and we were their trusted family friends, their father confessors, and the men like gods who performed miracles and could do no wrong.

But this blissful Utopian love affair between

the American people and the medical profession could not last forever, built, as it were, on the sands of unreality and sentimentality. Doctors were not angels, not infallible, not more patient or unselfish than other men. Patients did die, and some doctors did overcharge, and some surgeons did get themselves a little confused with God, and a few did advertise or take to dope or perform illegal abortions, and a few were incompetent, and a few became rich and indifferently callous to the sufferings of the poor; a few were misfits or dishonest, and a few were lazy and took no pride in their work, seeing nothing in it but a means of livelihood. Doctors were even then, as they are now, ordinary human beings, but enlarged in public opinion to king size. But the medical profession itself has always been a dramatic profession. It literally is, in a manner of speaking, a matter of life and death to each man on earth from the cradle to the grave. Medicine is of absorbing interest to all, and is always, never forget, in the public eye.

Fashions in heroes change, and the pendulum of admiration for the M. D. swung over to censure of him. Almost as much as the South, the medical profession became "target for tonight"—in invective, hostility, and open resentment of its shortcomings, and a whispering campaign opened fire. "*Red Book*" denounced ghost surgery, "*Cosmopolitan*" screamed about needless hysterectomies, Philip Wylie in a particularly uncomplimentary magazine article lumped M. D.s and chiropractors together as one and the same breed. Even the American College of Surgeons let out blast after blast against fee splitting, ghost surgery, and other evils it felt needed to be corrected, each blast sensationally reported in the national news magazines and the great and small newspapers of the land, and what was intended to be a mild in-the-family rebuke was seized upon as an over-all indictment against the good name of the profession as a whole.

To cap the climax, *Collier's* featured on its cover a color photograph of white-gowned surgeons with gleaming scalpels and masked faces, their eyes cruel and hard, sinister and gangster-like. (Any resemblance between them and the familiar painting of the kindly family doctor watching by a child's sick bed is purely coincidental!) Beneath the *Collier's* Dracula-like picture was the most complimentary title—"Why Some Doctors Ought To Be In Jail." The article itself was not as sensational as the title, but for every two patients who took the time to read the thing through, a hundred saw the damaging cover on the newstands.

In public opinion, it was now the doctor, not the patient who rode in the Cadillac, a Fleetwood, yet, and bought his wife the wild mink and the emerald clip. All doctors were said to live in $100,000 mansions, dubbed in derision, "Gallstone Gardens", "C a r d i a c Castle" or "Appendectomy Acres". "My money helped buy Dr. So-and So's new 27 inch television or his Chris-Craft or his duck pond." This cliché was good for a laugh at any time. Doctors were all millionaires, who had to "tote" home their loot in heavy crocus sacks, there to hide it presumably from the income tax collectors! They never took calls at night, and they let charity cases die neglected and unseen. It was the old case of when the patient died, the doctor killed him, and when he lived, God saved him.

The late Dr. Henry Bellaman, talented musician, teacher, literary critic, and author of many novels, unsung and unheralded, never produced a popular success until he hit the jack-pot with "Kings' Row". One of its leading characters was a surgeon, a sadistic butcher, who needlessly amputated both legs of an enemy out of sheer spite.

"Not As A Stranger", the current leader on the best-seller list of novels for spring, 1954, has for its hero, a heel who married the Swedish operating room nurse he scorned and despised to get her money to put himself through medical school. Another doctor character in the same novel is portrayed as thinking up the humane trick of wheeling aged charity patients to an unheated X-ray room at night in the fond hope that pneumonia would kill them off and make room for paying patients.

Thus, in fact and in fiction, the sights are trained on the shortcomings of the medical profession, and it would be wishful thinking

to say that public confidence in M.D.s has not been badly shaken. It is the doctors themselves, the patients charge, who are bringing on socialized medicine with their high prices and high and mighty ways. We have been soundly scolded for our ethics, for making the A.M.A. a sort of lodge or secret society, for professional jealousy, for conceit, sheer cussedness and pomposity, for exorbitant hospital costs, for being cold, inaccessible, unsympathetic men of science, for burying our mistakes, and even, God help us, for referring to patients as laymen!

How solidly based the indictment is or is not, is the $64 question I shall discuss with you, my colleagues and friends, today, closely bound as we are by the ties of a common devotion to the profession that we chose for our life's work. All of us here have felt the stress and strain of our responsibility as custodians of human life, sweated out tough decisions, kept a death watch over a close friend we weren't due to lose, and sent home cured the stranger doomed to die. We know the meaning of gruelling physical work, as well as any day labourer, and we have seen it take its toll too terribly many heart-breaking time of this colleague and that. "Poor Barry! A coronary, you say? How old was he? Forty-five! Feeling a little under the weather myself—I'll have to try to take things easier—well not now, but maybe next year."

In Stephen Paget's "Confessio Medici", he says of young aspiring fledgling doctors, "Calls, they imagine, should master men, beating down on them; surely a diploma, obtained by hard examinations and hard cash, cannot be a summons from Heaven. But it may be. For if a doctor's life may not be a divine vocation, then no life is a vocation, and nothing is divine." We may not think in such high-flown terms or feel our lives as doctors have been even partly divine, but each of us at one time *chose* medicine. We were not pushed into it, but we chose it as our natural bent and spent long, young, impatient years in training, and fought our way into practice.

I, myself, grew up in the home of a doctor father, and early felt the fascination of his calling. It honestly never occurred to me to choose another profession, but I was not hounded or driven to it by parental urging. I simply would not have known what to do with my life unless I had studied medicine. As much as I hate to admit it, I entered the University of Virginia Medical School in 1922, so for thirty-two years I have been subjected to medicine in all its many facets, and I have never had reason to regret my choice—not for long at a time anyway. Discouragement at times is the doctor's lot. During these thirty years, there have been many, many revolutionary advances in medicine, and I want to list briefly some of the ones that impressed me most, the list of necessity incomplete.

By the way, I went down to Atlanta for a meeting of the American College of Surgeons last year, and while there we had an amusing presiding officer at one session. Of course, everyone has heard the old saw about a specialist being one who knows more and more about less and less, but this gentleman had a new one. He said that a specialist was an S. O. B. with some slides! I am positive that I cannot qualify—as a specialist, but I do have some slides!

SLIDES

OUTSTANDING MEDICAL ADVANCES

1922—Insulin extracted by Banting and Best.

1923—Large scale immunization against diphtheria. Malarial treatment of paresis.

1924—Discovery of cause of scarlet fever by George and Gladys Dick.

1926—Maude Slye proved that certain types of cancer are inherited.

1927—Liver therapy for pernicious anemia discovered by Minot and Murphy. Later found to be Vitamin B_{12}.

1928—A. W. Adson of Mayo Clinic, operated on the sympathetics for Raynaud's disease.

1929—Isolation of the female sex-hormone.

1930—Landsteiner received the 1930 Nobel prize for the discovery that human blood falls into 4 great groups.

1931—Fleas found to be the carriers of typhus fever.

1933—First complete lobectomy reported by Evarts Graham.

1934—Sympathectomy for hypertension.
Synthetic production of male and

female sex hormones.

Prontosil or sulfanilamide—its use reported from Johns Hopkins.

1938—Use of nicotinic acid for pellagra.

1939—Shock therapy for psychoses.

Operation for patent ductus arteriosus.

1940—Successful vein grafting.

1941—Polio—carried by flies and may enter the body through the alimentary tract or through the lungs.

Gramicidin first used on humans and found effective.

Compulsory vaccination of troops against tetanus.

Troops vaccinated against yellow fever.

1942—Institution of Red Cross blood banks.

1943—Penicillin therapy introduced. Discovered in 1928.

Rh factor discovered.

1944—Gamma globulin used for measles and albumin for shock.

1945—Streptomycin introduced.

Successful operation for blue babies.

Thiouracil used for toxic goitres.

1947—Valvulotomy used for heart lesions.

1949—Cortisone and ACTH introduced.

1951—Polio virus first grown on tissue cultures.

1954—Possible effective vaccine for polio.

Now let us summarize. Practically all of the acute infectious diseases that were at times epidemic in the past have been conquered by vaccination. It has been many years ago since smallpox was licked, and in the late twenties diphtheria was almost obliterated. Now we are beginning a mass vaccination that we are optimistic will eliminate the last and most terrible of the known epidemic diseases—polio.

Furthermore, during this same period we have discovered drugs that will cure the infectious diseases that could not be eradicated by vaccination. First came the sulfa drugs, then penicillin and other antibiotics. At present, the tubercle bacillus is practically the only culprit left at large.

During these years, too, came into full flower the vitamin! Sometimes I think we are living in the Vitamin Age as well as the Aspirin Age and the Atomic Age! But levity aside, Minot and Murphy found how to cure pernicious anemia, a heretofore completely incurable disease, with liver. Later, B_{12} was found to be the active principle in the liver. We have niacin for pellagra, and vitamin K has proved a God-send to control bleeding in surgical cases.

The intricate workings of the endocrine glands have been examined and explored. Their functions are better understood and many of their active principles have been isolated and prepared synthetically. As mentioned above, Banting and Best in 1922, isolated insulin, a milestone of triumph in medical research, and recently cortisone and ACTH have become a latter-day miracle drug in the treatment of arthritis and other pain-wracking diseases.

In the field of surgery, the last two systems of the body have fallen prey to the scalpel. Up to the time of Evarts Graham, the lungs were considered inviolate. Since then, the heart has been attacked. The valves are cut, the large arteries and veins are rerouted, and both veins and arteries can be resected, or sections excised and grafted.

Perhaps, however, the greatest advances in surgery have come from a better understanding of fluid and electrolyte balance in the body and from the amazing improvements in anesthesia. Without the excellent anesthesia of today and without the availability of massive amounts of blood for transfusion, the spectacular operations mentioned, and many others of lesser degree could not be performed. Operations on the aged, once considered daring or hopeless, are now commonplace and are on the main as successful as in other age brackets, primarily because of intimate knowledge about these subjects.

What do these facts mean to us and to the public welfare? Along with great improvement in infant mortality, it means that normal life expectancy has been increased from 58½ to 70 years.

At this point, it might be of some interest to you to hear that in my father's presidential address to the S. C. Medical Association in 1909 he predicted, "If the five diseases, tuberculosis, entero-colitis, typhoid fever, pneumonia and diphtheria were prevented, the average life span would be increased 8 to 15

years." Two of these diseases can now be prevented, two can be successfully treated, and tuberculosis is the only remaining scourge.

In conclusion, consider for a few minutes one or two complaints against the medical profession. The public says we are a closed corporation, that there are not enough doctors to go around, and that we are trying to limit the number of students in our colleges. In 1922, we had one doctor for every 729 people in this country; in 1950 we had one for every 730 people, one more person per doctor. We have better doctors now for there are no longer any Grade B medical schools or any diploma mills.

During the past eleven years the enrollment in medical schools has increased 27%. In 1952, 6080 physicians were graduated, and the 1953 classes were even larger.

The A.M.A. has donated one and a half million dollars from its own treasury to support medical schools. Does that sound like the A.M.A. is limiting the number of doctors?

As to the cost of medical care, the average person today pays only 4% of his income for medical care, the same as his parents before him. Of this 4% the doctor gets only 28%, and the rest goes for medicines, hospitalization, etc. Twenty years ago the doctor got 32%, more then than at the present time.

Hospital charges have gone up faster than any other medical expense, but hospitalization is so shortened that often the hospital bill is lower than in the good old days. This quick hospital turnover is of course due to more effective drugs, modern equipment, improved surgical safeguards, and better over-all care.

Statistics alone, however, cannot convince our patients our prices are not too high—we are now suspect! But maybe someday you will have an experience to warm the cockles of your heart. Anyhow, a general practitioner friend of mine did. He was called recently to see a prominent and well-to-do plumber, found that said plumber had a mild attack of tonsillitis, and injected 300,000 units of penicillin. The patient asked cagily what the charges would be, and my friend told him $6—$3 for the house call and $3 for the penicillin. The patient frowned a minute, then smiled in friendly fashion and said, "Well, I guess that's about right, doc. When my assistant plumbers make a call, they charge $3 a house visit, and they charge extra for the materials."

With this encouraging story, I shall rest my defense of medicine, and end on a note of hope for its future.

As Dr. Harvey Cushing said in 1926, in his book of medical essays, "Consecratio Medici", "A spirit of devotion is the mainspring of our profession." Those are splendid words, and I say to you that in 1954, we still have that spirit—that and a pride in our profession, and in the good it has always accomplished and will continue to accomplish in spite of the avalanche of criticism hurled against us since World War II. In public opinion, our halo may have dimmed a little, but, human shortcomings notwithstanding, medicine is still a going concern.

Common Proctologic Problems[*]

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Mr. President, Members of the South Carolina Medical Association, Ladies and Gentlemen:

This morning you heard a young physician read an essay which was quite enlightening, and I am sure that you were inspired by it. It is very comforting to know that young physicians of today understand the problems which face the medical profession. Dr. Baker's presentation was down-to-earth and factual. The facts which he enunciated confirm the philosophy that the physician can no longer limit his endeavors to the care of the infirm. He now finds it necessary to do things which were not regarded very highly some years ago. He used to look with disdain upon activities which dealt with political problems. He felt that it was beneath the dignity of members of the medical profession to engage in any activity of a political nature. I agree with *everything* that Dr. Baker said regarding the exalted position which was once occupied by the American physician as compared to that which he now reluctantly has to accept because of unfavorable conditions which have existed in this country during the last 10 or 15 years. I hope you will accept his suggestions, because unless you and other men like you assume your responsibility in these matters, the outlook for the profession of medicine is indeed unattractive. This very sad state of affairs is owing to situations which have been largely beyond the control of physicians, but I believe that the American medical profession can solve the problems which face it, through men like Julian Price and "Buck" Pressly. They will agree that Dr. Baker has presented to you problems which you should accept as your responsibility.

And now to my assigned subject, "Common Proctologic Problems."

People are beginning to realize that it is not necessary to answer advertisements in newspapers and magazines in order to obtain relief for proctologic conditions. Quack institutions do not flourish as they did at the turn of the century. They have lost control of a large segment of proctologic practice because members of the medical profession have become awakened to their responsibility in managing conditions which afflict the anus and rectum.

When a patient consults a physician and admits that he has rectal trouble, probably it is quite a serious matter to him. Usually such individuals are reluctant to reveal their rectal problems. They have heard about the clamp and cautery, and flee from such methods to advertisements which describe "painless pile dissolvement methods" and "cures without the knife." It is only natural that they would want to seek some other type of assistance than that which is afforded by burning operations and other unsightly procedures which even now prevail in some hospitals.

Your first duty when a patient consults you is to find out what is wrong. You must examine him carefully and in order to accomplish this it is necessary for you to know how to take care of your patient while performing the examination.

Usually the patient consults you because he has pain. If he merely should be passing a little blood occasionally, I doubt that he would pay much attention to it. He might go to a drug store for an ointment or a suppository and that might end it unless the bleeding persists. However, if he has pain, he will consult you and you must show him unusual consideration if you hope to perform an examination satisfactorily. Too much emphasis cannot be placed on the importance of this examination. Approximately a fifth of the patients in

[*]Excerpts from an address read at the meeting of the South Carolina Medical Association, Myrtle Beach, South Carolina, May 11 to 13, 1954.

†The Mayo Foundation is a part of the Graduate School of the University of Minnesota.

whom I have discovered cancer have been treated for something else during the period of their symptoms and the cancer has remained undiscovered. It is a good rule *to assume that a patient has a cancer until you prove that he does not have one!* If he is willing to consult you, he is entitled to a thorough examination and you must accept that responsibility. If you do not intend to accept it, you should send your patient to someone else. Any surgeon, internist, gastroenterologist or general practitioner should be able to examine a patient's rectum.

Sixty per cent of the operations performed in this country today are done by general practitioners, and many such operations are done well. Many of those practitioners are not diplomates of the American Board of Surgery or members of an exclusive surgical organization. Nevertheless they occupy a high position in the communities which they serve, and they occupy that position because of their capabilities. Also, they know their limitations!

Proctoscopy

Now let us consider the subject of proctoscopy. Remember that your patient probably has summoned all his courage to come to see you. Are you going to increase his burden by telling him to take a dose of castor oil and come back tomorrow morning after he has taken several enemas? Are you going to tell him not to eat supper or breakfast? After such a routine he is a pitiful spectacle. When he reaches your office you place him in the knee-chest position in which he has to maintain himself while you attempt to examine him. There is a table which inverts the patient and relieves him of much effort. If you do not have such a table, you can arrange a patient over the side of a bed, and by placing his elbows on a pillow on the floor and allowing his legs to cross the bed, you can accomplish much the same result as that provided by the inverting table. In the inverted position it is possible for the abdomen to swing free and when the proctoscope is inserted into the rectum and the obturator is withdrawn, air rushes in, the intestines fall out of the pelvis and the examination can be performed satisfactorily.

I wish to emphasize here that proctoscopy should be preceded by a digital examination. If you suspect that there is a lesion high in the rectum or in the lower portion of the sigmoid, you should place the patient in the lithotomy position and do a bimanual examination with the index finger of one hand in the rectum and the other hand on the lower portion of the abdomen. The main objective of the digital examination preparatory to proctoscopy is to determine whether there is a painful condition or an obstructive lesion which will interfere with the proctoscopic examination. The index finger should be inserted carefully and slowly and if this can be accomplished there is little doubt that the proctoscope can be inserted, since most proctoscopes are made so that their circumference is about the same as that of the average index finger.

General anesthesia should not be employed —perforations have occurred during proctoscopy when general anesthesia has been used. Your patient's co-operation is necessary and of course it is impossible unless he can reveal his discomforts to you. You should speak kindly to him and encourage him to believe in you. Sometimes, in spite of your best effort, he will not accept a complete examination. Sometimes a short mesosigmoid or a growth may interfere with the progress of the proctoscope. After the instrument has been inserted through the anus, the obturator is removed and the remainder of the examination is conducted under direct observation. If the examiner himself has had a proctoscopic examination, he knows how it feels when the proctoscope enters the rectum and he can tell his patient what to expect. It is important to anticipate the patient's discomforts and explain them to him before he experiences them. Attempts to provide a formula for proctoscopy are futile.

Polypoid Disease

Now I should like to discuss with you the subject of polypoid disease, and in the beginning I want to issue a warning. If you find a polyp that is pedunculated and the bowel wall is not involved, you may fulgurate it. But if there is a broad base, the problem is different. You may fulgurate a polyp that has a pedicle and destroy it completely without destroying its point of attachment. But if it is attached to the bowel wall by a broad base, you cannot

destroy it completely by burning it off the bowel wall; you must also destroy that part of the bowel wall to which it is attached. There may be no microscopic evidence of infiltration but that should not delude you.

If the lesion is attached to the posterior rectal wall and occupies a position below the peritoneal reflection, you can destroy the polyp and also that portion of the bowel wall to which the polyp is attached. You can even destroy some of the tissues in the retrorectal space along with the glands adjacent to the growth. On the other hand, if the polyp is in the sigmoid in the mobile portion of the bowel which lies within the peritoneal cavity, fulguration could be complete only if the burning procedure were carried through the substance of the bowel wall and into the abdominal cavity. Usually polyps are adenomas and, I believe, all of them will become malignant if the host lives long enough; hence it is necessary to treat them radically. When thorough fulguration is impossible, a surgical operation should be employed in order to assure complete removal of the growth.

Frequently you will find a small polyp adjacent to a cancer. Whenever I discover a polyp, I redouble my efforts to determine if a cancer lurks nearby. In a series of 200 consecutive cases in which my colleagues and I discovered a polyp, we advised that it be destroyed; 4 patients did not follow our advice. Within a period of 4 years, all 4 patients returned and in each we found cancer at the site of the polyp.

Anal Abscess and Fistula

During the sixth or seventh week of embryologic life the hindgut projects downward, the proctodeum dimples in and they unite to form the anal plate. With the dissolution of the anal plate, the pectinate line is formed. Thus the junction of the anus and rectum is established. Above and below this line there is a definite differentiation between the vascular, the lymphatic and the nerve structures. The lymph drainage above this line passes into the sacral and the hypogastric lymph nodes and below that line it goes into the inguinal nodes. Above the line the venous drainage is into the caval circulation and below it the veins empty into the portal circulation. Above the line the nerve supply is sympathetic and below it the nerve supply is spinal.

The anal canal is lined by a transitional type of epithelium. At its cephalad border we find the papillae of Morgagni which overlap the mucous membrane to form the anal crypts. It is through the anal crypts (the crypts of Morgagni) that infection gains admittance and provides the undermining process which is responsible for fissures, fistulas, hemorrhoids and other conditions of an inflammatory nature. An abscess is the first physical evidence of the disease which eventuates in a fistula in ano. Prior to the development of the abscess, the patient is scarcely ever aware of any disorder and at that time there is rarely an opportunity to provide treatment. The proper method to adopt when dealing with the abscess is not always easy to determine but it is important. Often it is difficult to determine the opportune moment to incise the abscess. In general it is best to allow it to become fluctuant and to approach, as nearly as possible, the point of rupture. By waiting, the wall of the abscess may become well outlined and when the abscess breaks through the surface of the skin or is incised through a thin partition, the wall of the abscess becomes continuous with the margin of the skin. If the abscess must be incised through several centimeters of normal tissue, the cut surfaces become exposed to the purulent discharges and the patient may become very sick. Abscesses occur in many different situations as indicated by such terms as "ischioanal," "ischiorectal," "supralevator," "pararectal" and "pelvirectal." The type of surgical treatment is determined by such factors.

The abscess should be incised at its most fluctuant point by a cruciform incision. In this manner four points of tissue can be excised and a large opening remains. Unless the abscess is unusually large, the external opening provided by the incision should be as large as the widest dimension of the abscess. Often a finger is inserted into the cavity of the abscess. Such an exploration is not only unnecessary but dangerous, and if the pyogenic wall of the abscess is broken down by this

maneuver, serious systemic complications may arise. Thus, simple incision and drainage and provision of an adequate outlet are all that are required. Then the acute condition is allowed to subside, during which chemotherapeutic agents may be employed (the use of these agents in an attempt to abort the abscess usually is futile). It is then necessary to allow sufficient time to elapse for the abscess wall to contract into a fistulous tube prior to the curative operation of fistulectomy.

Physicians should impress upon patients the fact that incision and drainage of the abscess is not a curative procedure and that a second operation will be required. Unless this is done, patients may become discontented when they discover that a draining sinus persists and they may even seek assistance from another physician.

The difficulties which arise in the management of fistula in ano are largely owing to a faulty conception of its origin. Also, there is much confusion regarding the meaning of the terms which are used to designate it. For example, the terms "anal fistula" and "rectal fistula" are often used interchangeably but the conditions are not the same. Again, the term "internal opening" is employed almost universally to designate the portal of entry of the infection which caused the condition and is considered to be the primary source of the disease. The error of such usage can be understood when one realizes that an internal opening may exist high in the rectum where the abscess has ruptured into the bowel, instead of externally on the buttocks, as is usually the case. Such an internal opening has nothing to do with the origin of the fistula. Other difficulties associated with the management of this disease may be attributed to the fear of cutting the anal sphincters, the habit of packing the wounds and leaving the packing in too long, and improper or inadequate postoperative care.

The operation of fistulectomy consists in converting all of the fistulous "tunnels" into open "ditches." This always involves cutting of a portion or all of the external sphincter, and sometimes the internal sphincter (so-called) must be incised. The operation is completed by cutting away overhanging edges and excision of those portions of the fistulous tract which are nearest to the point of origin. Sometimes lateral tracts extend superficially and can be treated as a sort of marsupialization procedure.

The postoperative management is as important as any phase of the care of the condition. Wounds should not be packed excessively and the "packing" should not be allowed to remain in the wound cavity longer than 72 hours. When dressings are removed that early, it will be observed that the walls of the wound will bleed, indicating that no fibrous membrane of scar has lined the wound cavity. Thus, the walls of the wound will grow together if it is dressed daily and precautions are exercised in order to avoid packing the walls of the wound apart. Finally, with the adherence of the opposing walls of the wound, a block of scar tissue will be interposed between the cut ends of the anal sphincter, to which it will adhere, and upon action of the muscles, the outlet of the rectum will be closed as efficiently as if the muscle fibers were continuous.

The Clinical Significance of Peptic Ulcer From the Surgical Viewpoint

HENRY W. MAYO, JR., M. D.

The term "peptic ulcer" has been used traditionally to include not only the ubiquitous duodenal ulcer, and the somewhat less common gastric ulcer, but also the jejunal or marginal ulcer occurring after certain surgical operations, the uncommon peptic ulcer of the lower end of the esophagus, and the ulcer occurring in relation to a Meckel's diverticulum which contains secreting gastric mucosa. The last two forms are so infrequent in average clinical experience that they do not merit discussion here; the jejunal ulcer, so common in the days when gastroenterostomy was accepted as a definitive procedure for duodenal ulcer, should become more of a rarity as the criteria for an acceptable operation for duodenal ulcer are more universally recognized.

There is a good deal of evidence to support the suggestion that gastric and duodenal ulcer may be different diseases, although they are traditionally considered under the common term of "peptic ulcer", presupposing peptic digestion of gastric and intestinal mucosa as a causative factor, and although the histologic characteristics of lesions in these two locations are the same. A century ago, gastric ulcers were seen more commonly at autopsy than duodenal ulcers, but in the last three or four decades, the duodenal ulcer has become many times more common than its gastric counterpart. In addition, although the preponderance of duodenal ulcers in the male sex at the present time is well known, a century ago women were afflicted more frequently with this disease. From these statements, one may infer that duodenal ulcer is a disease which has increased commensurate with the greater complexity of modern civilization. Gastric ulcer is diagnosed with frequency in phlegmatic, lethargic individuals, but the duodenal ulcer, as a rule, is inseparably associated with the hyperkinetic, hard-driving "worry wart" type of individual, thus indicating a possible psychosomatic basis for the disease. The presence of gastric ulcer is usually associated with normal or low acid values in the gastric juice after histamine stimulation, but the presence of an active duodenal ulcer is nearly always associated with high acid values. The measurement of 12 hour nocturnal gastric secretion, which might be considered a measurement of the cephalic or inter-digestive phase of gastric secretion mediated through the vagus nerves, inevitably results in recording increased volume as well as increased acidity for those patients with duodenal ulcer, but this is not commonly true in the gastric ulcer patients. Finally, although the development of carcinoma in close relationship to a duodenal ulcer is practically unknown, carcinoma is a common complicating factor in the management of patients with gastric ulcer. With these ideas in mind, it becomes obvious, despite the common generic term "peptic ulcer", that one must consider the gastric and duodenal lesions separately from a clinical standpoint. In general, the duodenal ulcer is considered primarily as a medical problem, although many cases may require surgery ultimately, and conversely, gastric ulcer must be considered primarily as a surgical problem, although some cases may be satisfactorily managed by conservative means.

The definite cause of duodenal and gastric ulcer is unknown, but certain etiologic factors have become apparent. Perhaps the most important of these is the demonstrated ability of a mixture of hydrochloric acid and pepsin to digest gastric or intestinal mucosa, resistance to this digestion being diminished in the more caudal segments of the gastro-intestinal tract. The trauma of the passage of food materials along the lesser curvature of the stomach, and the "jet effect" of chyme squirted through the pylorus is also important, and these two factors have been taken into consideration in the conventional medical anti-ulcer therapy, as well

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as in surgical treatment of the disease. The previously mentioned psychosomatic factor has been seized upon by the vagotomists as well as by the proponents of anti-cholinergic drugs. Other factors, the importance of which is less obvious, such as vascular spasm or vascular stasis, allergies, nutritional deficiencies, and pre-existing inflammation, have received less attention from therapists, both medical and surgical.

Since there must be a definite difference in the clinical attitude toward the patient with gastric ulcer and the patient with duodenal ulcer, it is necessary that any patient with persistent dyspeptic symptoms have a proper radiologic study with fluoroscopy performed by a competent radiologist, not only to determine the location of the ulcer, but to determine its size, the degree of deformity associated with it; the presence or absence of partial obstruction, and to evaluate the possibility of the presence of associated carcinoma.

1. *UNCOMPLICATED DUODENAL ULCER.* There is general agreement that the uncomplicated duodenal ulcer is primarily a medical problem. Some of these cases can be cured, and many can be controlled, in the sense that diabetes mellitus is controlled by insulin therapy, with proper diet and medications. *In evaluating the results of such therapy, it is necessary to recall that duodenal ulcer is a disease of remissions and exacerbations.* Characteristically, there will be flare-ups in the spring and in the fall, with healing of the ulcer in the summer and winter, and it is not infrequent to observe temporary healing of an ulcer as a result of a restful vacation without medication. Enthusiastic internists, research men backed by grants from pharmaceutical houses, and particularly the drug house detail men, tend to tout the current method of treatment in vogue which they wish to emphasize, be it antispasmodic, a new form of alkali, an anti-cholinergic drug, or simply a modified diet, by showing X-Rays and case reports in the name of clinical research indicating that within two to three weeks after the institution of therapy the ulcer was healed and the patient was free of pain. The general practitioner is in a far better position to judge the efficacy of various forms of treatment for ulcer, since he has the opportunity to see the patient as soon as recurrent symptoms develop, whereas there are many defenses between the patient and the specialist. Certainly no cures of peptic ulcer can be claimed until the patient has been followed for a year or more. In many cases, once an ulcer has reached a chronic stage with the deposition of much scar tissue in its base, healing is by covering of this avascular scar tissue with thin "scar epithelium", which, much like the scar epithelium over extensively burned areas in the skin, tends to break down as a result of the slightest trauma, with the development of recurrent ulceration. In many cases, it will be the patient, and not the ulcer, who is refractory to treatment, and yet some of the failures to adhere to diet and medications will be on sound economic grounds. It seems unjust to deny these individuals the benefit of a surgical operation which should be curative in about 90% of cases. The same may be said for the patient who has repeated recurrences of uncomplicated duodenal ulcer, despite adequate therapy. Again, although several trials of medical therapy are justified, it seems equally unjust to allow such a patient to suffer indefinitely intermittent episodes of unbearable ulcer pain which is incapacitating, without offering him surgery as a possible curative procedure.

2. *PERFORATION*: Acute perforation of a peptic ulcer is a definite indication for emergency operation, which will usually involve simple closure of the perforation with a tab of omentum. If a gastric lesion is perforated, and simple closure is carried out, biopsy of the lesion should be taken in an effort to determine if associated carcinoma is present. At the Roper Hospital, it has been our practice to perform emergency gastric resection for those patients with perforated gastric lesions with minimal peritoneal contamination, who arrive in the hospital a short time after the perforation has occurred, and in whom the general physical condition does not contraindicate a procedure of such magnitude. In such manner, primary resection not only rids the patient of the ulcer diathesis, but eliminates the immediate threat to his life as well. In other clinics, there is a growing ten-

dency to perform primary gastric resection for cases of perforated duodenal ulcer seen shortly after the onset of perforation. We have adopted this procedure with some hesitancy, confining it for the present to those patients who have a long history of ulcer difficulties, previous perforation or hemorrhage, or a large chronic ulcer. Primary gastric resection in the face of perforation is a rational procedure, since about two-thirds of those patients who survive simple closure of a perforated ulcer will have later difficulty requiring strenuous medical or surgical therapy. Except in those cases arriving in the hospital in a moribund condition, and those in which there is a good deal of doubt about the diagnosis, conservative treatment with suction and antibiotics seems unwise, since the material contaminating the peritoneum is not removed, and since the size of the perforation and the location of the ulcer are not determined.

3. *HEMORRHAGE*. Between 80% and 90% of cases of bleeding from gastric or duodenal ulcers will be controlled with suitable hospital medical therapy, including the administration of an adequate amount of blood. A few individuals, particularly those in the older age groups, with large chronic ulcers situated on the lesser curvature of the stomach, or on the posterior wall of the duodenum, will develop hemorrhage resulting from erosion of large vessels which will be uncontrollable by such conservative measures, and which will require emergency gastric resection to avoid death from hemorrhage. Those cases in which the bleeding is not promptly controlled by diet, anti-acids, anti-spasmodics, and blood transfusions, and those in which the bleeding recurs despite such medical measures are definite candidates for immediate gastric resection, and others must be chosen on the basis of the combined clinical judgement of the internist and surgeon while the patient is under very close observation in the hospital. An older patient who recovers from a single episode of severe hemorrhage should be a candidate for elective gastric resection, and a younger patient who has had several similar episodes should be given the benefit of such surgery.

4. *OBSTRUCTION*: Cicatricial contraction of the pylorus resulting from recrudescences of duodenal ulcer may result in partial or complete obstruction of the pyloric outlet of the stomach with concomitant electrolyte imbalance and fluid deficits. Some cases of obstruction are of a reversible nature in that they are due to pylorospasm and edema at the pylorus, which will be ameliorated, at least in part, by the judicious use of antispasmodics, and perhaps the continuous or intermittent use of suction with a Levine tube in the stomach. Once obstruction on a cicatricial basis has developed, with marked retention of barium four to six hours after its ingestion, and without improvement on a trial of therapy with antispasmodics and intermittent suction, there is no drug which can relieve such a situation and surgery will be necessary. In most cases, subtotal gastric resection will be the operation of choice, although in those elderly patients who no longer have an active ulcer, and whose histamine gastric analysis shows low acid values, a gastro-enterostomy may be adequate. We reserve concomitant vagotomy and gastro-enterostomy for poor risk patients with high gastric acidity, and for those in whom a large inflammatory mass surrounds the ulcer.

5. *GASTRIC ULCER*. The gastric ulcer must be considered as a special problem because of the possibility of the presence of associated carcinoma. For years it has been debated whether these ulcer-cancers are due to sloughing out of the central portion of a carcinoma with acid-peptic erosion of this excavated area, or due to the development of cancer on the basis of chronic irritation. There is much to be said on both sides of this question, but the question itself is strictly academic. Gastric ulcers on the greater curvature of the stomach and in the prepyloric area must be regarded as malignant until proven otherwise by microscopic examination of representative sections of the whole lesion; thus, in these cases, with an occasional exception, gastric resection would be indicated without attempting conservative treatment. The most common variety of gastric ulcer, that situated on the lesser curvature, will be malignant in about 10% of such cases. Gastroscopy, certain x-ray criteria, acid studies, and material obtained from the stomach by the gastric balloon or

papaine technique and studied by Papanicolaou staining methods all will be of some additive value in suggesting the possibility that a given lesion may be benign or malignant, but the final determination will lie in microscopic examination. Moreover, ulcers on the lesser curvature and the posterior wall are likely to erode large vessels with resulting exsanguinating hemorrhage, or are likely to penetrate the full thickness of the gastric wall, eroding the pancreas. Once such penetration has occurred, healing seldom if ever occurs. Large gastric ulcers, even though healed temporarily, as indicated by x-rays, may recur again and again, either because the apparent healing was an indication of filling of the ulcer by granulation tissue or by carcinomatous tissue, or because the thin scar epithelium breaks down again with slight trauma. Consequently, it would seem logical to agree that all gastric ulcers should be attacked surgically if complete healing does not occur in two to three weeks of rigid hospital anti-ulcer therapy. Those ulcers which heal should be closely followed by further x-rays to insure against asymptomatic recurrence. When surgery is undertaken, subtotal gastric resection is indicated, vagotomy and gastro-enterostomy having no place in the treatment of gastric ulcer.

6. *JEJUNAL ULCER.* The jejunal ulcer was commonly seen, along with its dreaded complication of gastro-jejuno-colic fistula, in the days when gastro-enterostomy was in vogue, but is seen in less than 3% of cases in which a proper subtotal gastric resection is performed, removing the lower three-fourths of the stomach, and utilizing a short jejunal loop for the anastomosis. When such ulcers do occur after gastric resection, vagotomy appears to be valuable in their therapy, but for those ulcers occurring after gastro-enterostomy, gastric resection would be preferable.

SUMMARY

Gastric ulcer is a disease which may threaten the life of the individual in several different ways if it is not eradicated promptly, and thus must be considered primarily of surgical significance. Duodenal ulcer is a disease which frequently can be cured or controlled in its early stages by proper medical measures, but which must be seriously regarded if later complications requiring surgery are to be avoided. The old axiom "once an ulcer patient, always an ulcer patient" still prevails, and all cases handled by surgeons, internists, and general practitioners should be followed carefully for years afterward. Patients who develop repeated recurrences of ulcers, duodenal or gastric, will probably never return to normal health without the benefit of surgical intervention.

IVORY TOWER MEDICINE

It is regrettable that our great medical centers, because they have become citadels of scientific progress, are frequently and thoughtlessly dubbed "ivory towers," with the implication that they have lost the human touch. In speaking of ivory towers I should like to suggest that, if possible, the precious stuff of which the tower is made be forgotten. "Ivory" does for "tower" what "mink" has unfortunately done for "coat." Let us rather emphasize the "tower." One can be lofty without being aloof. A tower is after all a height from which one gets an expanded view of the horizon, a height from which one can still see the achievements of yesterday in the full perspective of the possible accomplishments of tomorrow.

The caption "horse and buggy" doctor by its very contrast with "ivory-towered medicine" illustrates a major trend that has had and still has a place in providing medical service to the public. Instead of doctors visiting the home, patients now visit the diagnostic clinics and the hospitals. This is especially true in the urban areas. It is not entirely due to a change in attitude on the part of physicians. Often it is not realized that not only is the "horse and buggy" doctor disappearing but also "the horse and buggy home." I wish merely to comment that the factors related to the change in medical service from a "home delivery system" to a "cash and carry" basis are complex and involved. In spite of shortcomings, the new trend is providing better medical care to the population than it has ever had before.

A. E. Severinghaus

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Surgical Management of Peptic Ulcer

CRANSTON W. HOLMAN, M. D.

I should like to summarize for you some of our experiences at The New York Hospital in the surgical management of peptic ulcer.

In spite of the ever-increasing variety of operations available, the surgical therapy of peptic ulcer is still primarily directed towards its complications — namely, perforation, obstruction, hemorrhage, and carcinomatous change. This statement should be qualified, however, by adding that early operation is frequently advocated for gastric ulcer because of the possibility of malignancy, while, conversely, we are reluctant to advise operation for the uncomplicated duodenal ulcer. This general policy results in our operating upon approximately ten per cent of patients who are under treatment.

PERFORATION: The treatment of perforation is immediate operation. There have been several reports in the literature advocating conservative treatment with antibiotics and constant gastric suction, a method that few surgeons recommend.

In any active surgical clinic, it is not an uncommon experience to find at operation the perforated ulcer to be a centimeter or so in diameter, with edges indurated and with gastric contents pouring into the peritoneal cavity —a situation unlikely to be dealt with by nature in a satisfactory manner.

However, in these troubled times, the reports on conservative treatment have served the purpose of establishing a method that can be used to good advantage on small ships at sea where operative treatment is not available.

OBSTRUCTION: The symptoms of obstruction may be due to actual scarring, to edema associated with an exacerbation of an ulcer, or rarely, merely to spasm of the pylorus. These patients should be hospitalized and placed on some form of Sippy regime including vitamins, sedatives, and antispasmodics. Supplemental parenteral fluids are given if indicated. Every evening the stomach is lavaged in order to determine the degree of retention and so that the stomach may be empty during the sleeping hours. If a pyloraspasm is suspected, we have found useful the administration of 1/50 of a grain of atropine, with sodium phenobarbital, as premedication for a gastrointestinal examination. More than once, barium passing freely through a large patent pylorus has proved that a suspected true obstruction is nothing more than pylorospasm. This fortuitous finding has in my experience been limited to those patients with symptoms of recent origin.

Obstruction due to edema should respond to therapy within ten days to two weeks. If the patient's symptoms are of several years duration or if cicatricial stenosis is demonstrated by x-ray, operation is indicated after conservative therapy. One or two weeks of preliminary treatment is advisable so that the size and tone of the stomach may be restored to as nearly normal as is possible and also to allow for correction of any abnormality of the blood constituents.

Gastric resection is the procedure of choice, but it is in this group that gastro-enterostomy may be profitably used in the aged patient or in the presence of coexisting disease which dictates election of the simplest procedure.

We, like others, found that patients with obstruction fared better after operation than those without, and as you know various explanations for this have been proposed. One of the most popular notions predicates that the patients with pyloric obstruction generally have low acidity and therefore after operative relief of the obstruction there is little reason for continued irritation of the ulcer.

Others consider that scarring and obstruction represent the terminal phase of healing and relative inactivity of the ulcer. The latter view is supported by the fact that cicatricial obstruction occurs most frequently in the middle and older age groups, a period of life not so hampered by the aggressive drives and emotional stress of younger ages.

Our studies favor the latter thesis. In a

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group of seventy-five patients, the gastric acidities following gastro-enterostomy were much the same whether or not a pre-operative pyloric obstruction existed.[1] In the post-operative follow up, however, eighty-five per cent of the patients with obstruction had a satisfactory result in contrast to only a sixty-five per cent good result for those without obstruction. Also, except in a very few patients, gastro-enterostomy does not alter the acidity—possibly the major reason for its failure in many cases.

BLEEDING: Bleeding to a dangerous degree is the most common complication of peptic ulcer and, excepting perforation, is the most disturbing. The proper treatment of severe bleeding from peptic ulcer remains a problem for which widely divergent solutions are suggested, and few subjects are more controversial. Different factors influence this wide variation of honest opinion, but, at any rate, it almost invariably leads every large clinic to formulate policies based upon its own experience. This we also have done. During the years 1932 to 1940, all patients were treated by conservative measures, and in a group of 161 patients the mortality was approximately 14 per cent. Each year during this time, we would lose one or two patients who we thought might have been saved by operation to control the bleeding. Because of this, in 1940 we made a critical analysis in the hope of determining what factors were primarily responsible for our poor results. This study,[2] which led to a change in therapy, I should like to summarize.

It was found that conservative treatment led to a high mortality in the following two types of patients. (1) Those who continued to bleed massively for forty-eight hours in spite of rigid conservative treatment; (2) Those with previously uncomplicated ulcer who started to bleed in the hospital while receiving supposedly optimum medical therapy.

In addition, since most of the patients in these two groups were over forty years of age, it followed that the older the patient—the higher the mortality.

THE POLICY OF IMMEDIATE SURGICAL INTERVENTION IN CERTAIN CASES: These findings led to a policy of immediate operation for patients of the two types mentioned above, and, since 1940, the mortality rate has been reduced to five-plus per cent. This gratifying decrease is attributed with some confidence to the promptness of operation since other variables that might influence results remained unchanged. During both periods all patients were of the ward class, interpretation of the severity of hemorrhage was determined by the same standards, and surgery was performed by supervised resident surgeons, all trained by the same methods. To be sure, although the general policy dictates immediate operation for these two types of patients, it is realized that no hard and fast rules can be routinely followed when treatment is outlined for each individual patient. For instance, one patient, several days after being admitted to the hospital because of hemiplegia, developed relentless upper gastro-intestinal bleeding, but his poor general condition as a result of his paralysis precluded operative treatment.

Brief comment should be made about what influence the location of the ulcer and additional coincident complications may have upon treatment. Sandusky and Mayo[3] report a mortality for gastric and duodenal ulcer of 30 per cent and 5.4 per cent respectively—a more striking difference than that encountered in our experience.

Bleeding from a marginal ulcer secondary to either gastric resection or gastro-enterostomy is not so serious as that from a primary ulcer. This is probably best explained by the fact that many times the secondary ulceration occurs in the jejunal side of the anastomosis where the vessels are relatively small. However, on rare occasions, immediate operation is indicated in cases of terrific bleeding when it appears obvious that some large vessel has been eroded. One such patient came under our care and died rather quickly after having bled fitfully for seven days. At autopsy it was found that a large anastomotic ulcer had eroded the superior mesenteric artery.

The simultaneous or immediately successive complications of perforation and hemorrhage are particularly serious and offer rather a dismal prognosis. Either combination, perforation and then bleeding or bleeding and then perforation, is best treated by gastric resection in

spite of the technical difficulties that may be encountered.

MANAGEMENT OF SERIOUS GASTRO-INTESTINAL HEMORRHAGE: In our present management of serious gastro-intestinal hemorrhage, preliminary steps include the placing of the patient in a hospital, early consultation between physician and surgeon, and immediate arrangement for transfusions. All patients are first placed on a conservative regimen, which includes complete bed rest, sufficient sedation to keep the patient comfortable and free from anxiety, adequate blood replacement to maintain a normal blood volume, and, for the first few hours of observation, nothing by mouth. This routine is followed with a definite purpose.

In the first place, patients who bleed are apprehensive and agitated, which contributes to their general restlessness. It is important to reassure them, to provide quiet surroundings, and to make them as comfortable as possible.

In the second place, immediate blood replacement should be begun. There is no evidence to support the belief that giving a blood transfusion will increase the patient's blood pressure to a point that might stimulate the recurrence of bleeding. Costello[4] emphasized the importance of administering large amounts of blood, and considered this practice responsible for the mortality rate of less than 5 per cent that he attained in a group of seventy-six patients treated for massive upper gastro-intestinal hemorrhage due to a variety of causes.

Third, the policy of withholding everything by mouth during the first few hours of observation is recommended because occasionally when fluids and food are allowed hematemesis recurs. After the patient becomes accommodated to his new surroundings and the first excitement of hospital admission has passed, the decision whether or not a restricted diet is to be given should be determined by whether or not the patient is hungry. This simple rule fulfills most of the theoretical factors involved in determining whether or not the stomach containing food is less likely to bleed. Hunger pains indicate existent motility of the stomach, which can be reduced or eliminated by feeding. On the other hand, in patients who are nauseated or who do not wish food, feeding may initiate vomiting and contribute to a recurrence of bleeding.

Immediate surgery during the period of active hemorrhage should be considered only after the diagnosis of ulcer has been established beyond reasonable doubt since a variety of conditions share bleeding as their most prominent symptom. Usual causes for bleeding other than ulcer, such as esophageal varices, the blood dyscrasias, and carcinoma, can be readily determined. In addition, if there is real doubt as to whether the bleeding originates from an ulcer and if no other cause for the bleeding is apparent, operative treatment is not indicated. It cannot be over-emphasized that once operation is decided upon for a patient, the sooner it is undertaken the better, since, as Finsterer[5] has shown, the operative mortality varies directly with the duration of bleeding. To delay in the hope that the bleeding will stop is dangerous—certainly every one expresses pessimism for those who fail to improve after prolonged conservative treatment and who are operated upon as a last resort.

If operation is decided upon, gastric resection is the procedure of choice, to ensure both immediate control of bleeding and a satisfactory permanent result; and, although it may seem a formidable procedure in a person debilitated by blood loss, it is surprisingly well tolerated.

Occasionally when we are doubtful about the cause of bleeding but feel that an ulcer is responsible, a limited gastric x-ray examination may be useful. In this event, the operating-room is alerted when the patient is taken for the x-ray study, and if ulcer is found, the patient is taken directly to the operating-room.

When operation is planned in a patient in whom ulcer is suspected even though there is no x-ray evidence, the surgeon is faced with the possibility of being unable to locate the bleeding point. Of over 400 cases observed at operation or autopsy, in only five was it impossible to locate the source of bleeding. But, however slight the possibility, failure to find the source of hemorrhage even after gastrostomy is a most frustating experience. Some judge that, in spite of such a failure, gastric

resection should be done; with this I cannot agree. As an alternative, ligation of all of the vessels along the lesser curvature of the stomach is recommended.

Finally, what happens to those patients, approximately 87 per cent, who recover from their bleeding under a conservative regimen? Our findings, and those of others, reveal that over 50 per cent of these patients will bleed again, and 75 per cent will have symptoms that require medical attention. These are potent arguments for surgical therapy, and, although each individual case must be judged on its own merits, it would seem reasonable to advise operation on those patients over 40 years of age who have bled from an ulcer that has been recurrently active for a period of years.

In summary, then: Patients who bleed should be hospitalized and placed on a conservative regime. If, after 48 hours, bleeding continues, operation is indicated, particularly if the patient is over 40 years of age. Immediate operation should be performed on those patients who begin to bleed in the hospital while they are being treated for a previously uncomplicated ulcer.

GASTRIC ULCER

Because of the ever-present threat of malignancy in every gastric lesion, the uncomplicated gastric ulcer, in contrast to the duodenal ulcer, is always considered a possibility for early surgical treatment. This policy of early operation upon gastric lesions developed from the experience that an *incorrect* differential diagnosis between carcinoma and benign ulcer occurred too often to warrant conservative treatment over a long period of time.

About fifteen years ago a review[6] of our proved gastric lesions emphasized the difficulty of establishing a correct diagnosis. We found that it was impossible by any *single* method to make a definite diagnosis in approximately fifteen per cent of the patients.

It should be emphasized that this figure does not represent mistakes in diagnosis but rather the inability to conclusively establish the correct diagnosis. Nor does this finding represent mistakes in therapy; most cases were treated properly, since one or more of the diagnostic procedures pointed to the correct diagnosis. This study did prove, however, that if any single method of examination indicated the presence of malignancy—such as, a palpable mass, an x-ray suggestive of cancer, or an anacidity—immediate removal of the lesion was indicated.

Also, these findings emphasized that all methods of diagnosis should be used and, in particular, I wish to mention the gastric analysis—an examination that at the present time has been all but abandoned by some. Bloomfield and Polland[7] demonstrated its usefulness if the test was done carefully, and they found, as have others, that a benign lesion is so rarely associated with an anacidity that, whenever a gastric lesion is associated with an anacidity, it must be considered malignant until proved otherwise by microscopic examination.

Case Report: A 54-year-old woman had symptoms of indigestion for several years, negative physical findings, and an x-ray that revealed a gastric ulcer on the lesser curvature. On two occasions, an anacidity was found by gastric analysis. On conservative therapy, the patient's symptoms disappeared, the ulcer became smaller and then the patient failed to return to the clinic until five months later when her symptoms recurred. X-ray examination at that time revealed a recurrence of the ulcer with some characteristics of malignancy. The patient finally agreed to operation and at operation a carcinomatous ulcer was removed. In this case, the anacidity was the only early indication of a malignancy.

SUMMARY

Perforation of a peptic ulcer should be surgically treated.

Cicatricial pyloric obstruction is best treated by gastric resection. However, it is in this type of patient, that simple gastro-enterostomy may be useful.

Massive bleeding from a peptic ulcer should be considered an indication for immediate operation if (1) the patient continues to bleed for over 48 hours, (2) the patient begins to bleed while in the hospital receiving treatment for a previously uncomplicated ulcer.

Surgical therapy should be considered for all gastric ulcers. Immediate operation is indicated if any examination suggests malignancy or if the ulcer fails to show evidence of

healing within a month's time.

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Please send in promptly notice of change of address, giving both old and new; always state whether the change is temporary or permanent. Original manuscripts, subject to approval by the Editor and the Editorial Board, are desired for publication in the Journal. They should be typewritten, double spaced, on 8½ x 11 paper. References should be complete, and only such as relate directly to statements quoted in the paper. Illustrations will be used as funds permit, or as authors are willing to bear the necessary increase in cost. Short original articles are preferred to long reviews.

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SEPTEMBER, 1954

Charity at Home

Were the physician to respond by giving to every cause whose appeal comes to his desk, he would have to be rich as Croesus and generous in proportion. Often he would be giving to spurious efforts and would be lining the pockets of enterprising promoters.

An appeal from united community campaigns, the "Red Feather" and such, implies an endorsement of the worthiness of the participating agencies and organizations. It asks for a lump sum, it offers one appeal instead of the many which we formerly heard, it saves our time and effort and the labors of a host of volunteer workers. It is organized, supervised, justified charity.

Often a physician feels that he makes intangible contributions in unrequited professional services, and should not be expected to give to community campaigns. Such services are a normal part of his calling and are to be expected from all true physicians. They do not relieve him of the responsibility of helping materially insofar as he can with civic charities.

The physician is not a big benefactor of organized community efforts. The average physician gives about $48.00 to "chests" and $74.00 to funds, but only six out of ten give at all to chests and only eight out of ten give to funds.

We could do better, without pain.

Naturopaths Bring Suit

The situation with respect to the practitioners of naturopathy in South Carolina seems to be approaching a climax, with the initiative being taken by the naturopaths themselves. On June 22, 1954, suit was instituted against the Attorney General of South Carolina in the Court of Common Pleas for Spartanburg County by M. S. Dantzler and J. D. Branyon, described respectively as the president and secretary-treasurer of the State Naturopathic Physicians Association. In this proceeding they seek a declaratory judgment of the Court, interpreting the statutes of the State as conferring upon licensed naturopaths the right to prescribe, dispense and administer "all drugs of botanical origin, including opium and all of its derivatives." The Complaint alleges that the naturopaths "are being arbitrarily, unjustly, and unlawfully . . . . limited and restricted in a manner not warranted by law," as the result of various opinions rendered from time to time by the present Attorney General, T. C. Callison, and his predecessor-in-office.

The statutes clearly do not give any specific authority to the naturopaths to do the things they claim and the Attorney Generals, past and present, have so ruled on more than one occasion. Their contention now seems to be that such authority is to be implied from the use of various terms included within the definition of Naturopathy, as carried in the original statutes and the amendments. The Complaint in the case alleges that the naturopaths are fully qualified by training and education to deal in these drugs, and that through the opinions of the Attorney General, referred to, "their rights, privileges and immunities (have been) destroyed, hampered and illegally interfered with."

The proceeding is patterned after one instituted by the naturopaths in Florida more than a year ago and completed early this year upon the decision by the Supreme Court of

that State, after a second hearing on appeal. The appeal originally was determined against the naturopaths but petition for rehearing was granted and following argument the second time, the Florida Court reversed itself and held in favor of the contention of the naturopaths there. In April of this year the Attorney General of Florida rendered an opinion consistent with the final decision of the Supreme Court and the naturopaths in that State apparently now are authorized to do the things for which they seek authority in South Carolina.

The Executive Secretary and Counsel of the South Carolina Medical Association received information about a year ago that some such proceeding probably would be brought. He brought it to the attention of Council at its meeting in September 1953, and at that time was authorized, in the event suit were brought, to file a brief *amicus curiae* and to take further action on the Association's behalf if indicated. Obviously, commencement of the proceeding in South Carolina was postponed until after final determination of that in Florida, and the result there will probably be pressed strongly as a precedent in the South Carolina case. It will not, of course, however be binding upon the Courts in this State.

Immediately after the institution of the proceeding, the Association's legal counsel conferred at length with the Attorney General, and in view of his knowledge of the general situation and interest in the matter on behalf of the Association, was requested to be associated with the Attorney General's office in the defense of the suit. We were able to place in the hands of the Attorney General considerable background material and information concerning the Florida case, which apparently may be of considerable value.

A Demurrer to the Complaint has been filed on behalf of the Attorney General, this pleading being designed to test the strictly legal basis for the action and the Plaintiffs' right to maintain it. It takes the position, briefly, that the statutes are entirely clear in their provisions, that they mean what they say, and that under no reasonable or proper interpretation can their language be construed to extend the authority of the naturopaths to the lengths suggested. The matter will be heard by a Circuit Judge in Spartanburg, probably during the early part of September. If the Demurrer is sustained, that will end the matter so far as the present action is concerned, except of course, for the probability of an appeal to the Supreme Court. If the Demurrer is overruled, the Court will doubtless allow the Defendant to answer, and thereafter, additional issues will unquestionably enter the proceeding—issues of fact as well as law—which will be determined by the Court in a subsequent hearing.

Attorneys for the Plaintiffs are Sam R. Watt and T. E. Walsh of Spartanburg; and for the Defendant, T. C. Callison, Attorney General, James S. Verner, Assistant Attorney General, and M. L. Meadors.

The naturopaths during the past several years have broadened their field of activity considerably, and to such an extent that many of them now exercise virtually the same prerogatives of practice as those rightfully held by doctors of medicine. If the Court should hold in line with their contention in the present suit, it would be hard indeed to distinguish any line of demarcation between their rights of practice and those of the doctors of medicine.

For the benefit of the public, therefore, it seems that the medical profession should take a positive stand and discharge its responsibility in giving the Attorney General and the Court full information concerning the actual situation, particularly as it concerns the background of medical training and experience of the holders of the licenses to practice naturopathy. While the Association is not in name a party to the suit, its interest therein and support of the position of the Attorney General will be clearly understood. The Chairman and other members of Council have been consulted from time to time on the action taken thus far, which, as stated above, is in line with the official action directed by Council nearly a year ago.

In other phases of the same matter, it will be recalled that Resolutions were adopted by several county and district medical societies this spring, calling upon the Attorney General to use the facilities of his office in making a

thorough investigation of the schools or institutions furnishing whatever scientific training and education the naturopaths may have, so as to determine, if possible, the basis of their right to license as practitioners of a healing art. Prior to commencement of the action, it is understood that the Attorney General had called upon the Secretary of the Board of Naturopathic Examiners for a list of the licensees in the State and that this request had been partially complied with.

In the latest development which has come to our knowledge, the Barnwell County Medical Society, on June 25, went on record by unanimous vote to call the situation to the attention of that County's long-time, prominent member of the House of Representatives, Speaker Solomon Blatt. The Barnwell County physicians, through their secretary, state that, "as doctors of medicine, we regard this increase (of naturopaths) with foreboding, realizing . . . . . that the citizens of our State are ever increasingly exposed to that which we consider inferior medical care in all its details." The letter calls attention further to the fact that naturopaths are licensed in only about eight states, and that the laws under which they were formerly licensed in Tennessee were repealed in 1947.

The action of the Barnwell County Medical Society calls for repeal of the law in South Carolina and requests the cooperation of Mr. Blatt in that effort. Activity directed toward the same general end in the past years has met with very good success in the House of Representatives. The Senate of South Carolina is where the chief difficulty has always arisen, and will probably arise again.

M. L. Meadors

A Judgment for Solomon

Concern for the child with cerebral palsy has increased greatly in recent years, and many efforts have been made toward remedial action. Especially has the National Society for Crippled Children and Adults worked toward the betterment of educational and therapeutic conditions, and its constituent, The Crippled Children Society of South Carolina has concentrated primarily and very successfully on measures to aid the palsied child. Through the sale of Easter Seals, funds have been raised for an ever-expanding program and activities are carried out in many parts of the state.

Lately there has appeared on the local scene another national organization known as the United Cerebral Palsy Association, an organization approved for fund raising and proposing to aid the palsied child by material benefit and by research. One fourth of the funds raised goes for the latter purpose. The rest goes for local effort as determined by local chapters, of which one or more have been already organized in the state. The Crippled Children Society likewise has a provision for research, but nine-tenths of its funds are expended in the area in which they are raised.

It is doubtful that anyone will question the desirability of raising funds to help the palsied child, and surely the field for research is wide and inviting. But there is a danger that in heeding the sentimental and emotional appeal which must carry much weight in a desire to help the child the interested person will overlook or disregard certain practical considerations.

One of these is the near certainty of confusion and competition between two organizations aiming at the same goal. Already the public is confused and no doubt many of the physicians are vague in their conception of the relations of the societies. Multiplication of drives and appeals will bring further confusion and perhaps divide interest and money necessary to the success of any campaign. Existence of competitive chapters in communities will not be helpful in running smooth programs, and the expenditure of efforts and funds in conducting campaigns will be duplicating and confusing.

The United Cerebral Palsy Association has come into South Carolina without an announced specific program, without consultation with the active and long established Crippled Children Society, and without preliminary conference with the State or County Medical Societies. It has preceeded to set up chapters and to conduct a highpressure, big business type of collection campaign in one community. It has no data to indicate the needs which its funds might satisfy, it has no

medical advisory committee on the state level, it has no definite statements as to its future relations with other organizations. Indeed in our opinion its approach has been devious and its gilding of the quoted word has been most questionable. Whatever its final aims may be, its approach has not been pleasing to those who have followed developments closely.

It may be that our information does not cover all aspects of this present conflict. It may be that better relations can be developed and that a cooperative enterprise may result in a well coordinated approach to the goal which is the same for both organizations. We quarrel with the method, not with the end.

Meanwhile, is such an organization to supplant or injure an older established body which has worked hard and conscientiously to improve the lot of the palsied child? Scripture does not say whether the judgment of Solomon involved a healthy child or one afflicted. It would seem not difficult to guess what his judgment would be in this present instance.

Blue Cross — Blue Shield

The Executive Director and I have recently studied analytically over 200 bills submitted by hospitals to the Blue Cross Plan. These bills had raised some question in the Claims Department.

What we found was quite interesting, rather surprising, and helps to explain why subscription charges, based on expected average utilization, hospitalization only when hospitalization is indicated, and expected average x-ray and other laboratory examinations and expensive drugs, have failed to meet the costs of hospital care for our subscribers. It also helps explain why there is a general complaint against the high cost of hospital care.

Let me mention briefly some things we found during a study of those bills.

The operating room charge for circumcision of a six-year-old boy was $30.00 in one hospital and was $20.00 in another—surely not the doctor's fault, but seeming excessive charges.

Two children were hospitalized for treatment of intestinal worms—one of round worms and one of hook worms. The round worm case was kept in hospital eleven days, and the hospital bill amounted to $89.60. The hook worm case was hospitalized for 4 days.

There was a small group of cases hospitalized with a diagnosis of pyelonephritis. They were kept in hospital two days, at a cost for each of over $69.00. Apparently they were hospitalized for cystoscopy and pyelograms. However, neither the admitting diagnosis nor the hospital bill intimated that they were hospitalized primarily for diagnositc study.

A case of appendicitis, hospitalized for six days received $8.00 worth of drugs, but x-ray examinations were charged at $85.00 and laboratory fees amounted to $69.00.

A case admitted as acute hepatitis was kept in hospital only one day. A case of "back strain," hospitalized for three days, received x-ray examinations costing $20.00. Laboratory fees amounted to $17.50. X-ray charges for a case of intermittent tachycardia were $50.00. One case of nephrolithiasis received x-ray examinations costing $90.00. One case with an admitting diagnosis of nervous exhaustion was charged $35.00 for x-ray examinations.

Investigation has revealed several things: many admitting diagnoses were not the final diagnoses. There can be no fault with that, but frequently the given admitting diagnosis appears to have been an effort to justify hospitalization for treatment, when in fact it was primarily for diagnosis. Some of these cases could have been handled just as well as outpatients.

X-ray examinations were made frequently at the request of the patient and had no bearing upon the condition for which he was receiving treatment.

Hospitalization was demanded by some patients in order, as they admitted, to save them the cost of expensive drugs. At least some of these hospitalized conditions are ordinarily treated as ambulatory office cases.

As long as human nature is what it is, efforts will be made to coerce doctors to order hospitalization and to order examinations and treatments which are not needed. It presents a difficult problem to us doctors. That being the case, the admitting diagnosis should be so stated as to indicate *why* the patient was hos-

pitalized rather than to state a comprehensive diagnosis—fever, severe pain, shock, for cystoscopy, for operation, for blood transfusions, etc. X-ray examinations, EKGs, and laboratory examinations not consistent with the diagnosis and not necessary but simply coincidental with the treatment should be so labeled so that the hospital may charge the patient for these non-covered services.

Patients won't like it, I admit. However, it is not fair to allow a few greedy people to wreck the Blue Cross Plan or drive its charges so high that those who need Blue Cross most cannot afford it.

There is no desire to deny anyone the hospital services he needs, nor to criticise nor restrict the doctor's management of any case. On the other hand, it is necessary that the cost of the services paid for by the Plan does not exceed its subscription income. It is felt that already subscription charges have reached the stage of diminishing returns. To raise them again would not only drive out of the Plan many who need it most, but it would so increase the per capita cost of administration that the balance left for payment for hospital services would not be greater than now.

An effort is being made to impose more strictly the waiting periods, the demand that x-ray and other examinations be consistent with the diagnoses before they are covered, the rule against hospitalization for domiciliary care, and the reduced liability of the Plan for hospitalization primarily for diagnostic studies. To do this requires considerable correspondence by the Plan, the member hospitals and the doctors. This is expensive and troublesome, and delays the payment of hospital bills.

Some changes in coverage and administration that are being considered: A more complete and accurate statement of diagnosis before hospital services are authorized; a limitation of the liability of the Plan for drugs and medications; a restriction of liability for costs of x-ray studies to the percentage of such charges retained by the hospital under terms of its contract with the radiologist; a routine deduction of some amount from the costs of each hospitalization (perhaps the cost of two days board and room charges or some fixed routine deduction).

What will ultimately come out of these considerations, the writer does not know. However, necessity knows no compromise. The just obligations of the Plan must be paid. Those obligations must either be further limited and restricted, or what appear to be abuses must be terminated.

J. Decherd Guess, Medical Director

Blue Cross - Blue Shield

Waiting Periods

No feature of the Blue Shield and Blue Cross contracts is less understood by the doctors and the members than is the imposition of a waiting period of one year before the treatment of pre-existing surgical and medical conditions is covered. Neither is there a feature which gives rise to more complaint, bickering, and disappointment and eventually to more ill will.

Even though the requirement of a waiting period has all of those faults, it is absolutely necessary. There are two important things to remember about it. The first is that after a year's membership, all illnesses covered by the agreement become covered even though they may have been present at the time of joining the Plan and they remain covered during the individual's lifetime, provided he continues to pay his dues. He is privileged to continue his membership on a direct billing basis even after retirement or withdrawal from the group.

The second thing to remember is that by imposing a waiting period for pre-existing conditions, the cost per member is much lower than it necessarily would be if there were no waiting period.

In large groups, which were not organized primarily to secure group insurance, and particularly in large groups of healthy industrial workers, the waiting period can be eliminated. The cost of treatment of pre-existing conditions spreads so thinly through the group that the increased cost per contract is not excessive. Similarly, groups that have already been insured by a commercial carrier for a year or longer, presumably have had already existing illness cared for, and the waiting period requirement may be waived.

Small groups, and particularly small groups in which only a part of the group applies for membership, and individual applicants are likely to be weighted against the Plans. Individuals who know or suspect that they will need early treatment will surely wish pro-

tection against the cost of such anticipated treatment. The Plans must of necessity either deny membership to these seekers of benefits for which they do not pay or they must institute protective barriers against what otherwise would be certain loss. The waiting period is one such barrier.

Our Blue Cross Plan writes into the subscription agreement the waiting period provision in rather general terms. It reads:

"Hospital services will not be provided during the first twelve (12) months of membership for any ailment, disease or condition existing on the effective date of the Subscription Agreement, or for which medical-surgical treatment or advice was rendered within one year prior to such effective date."

It is not necessary that the subscriber know of such a diseased condition, or that either a tentative or a positive diagnosis has been made or that he has received treatment for it within one year.

Either diagnosis by a doctor, medical treatment or recognition of symptoms of a disorder by either the doctor or the patient makes the application of the waiting period mandatory.

Also when no symptoms have been recognized, no diagnosis has been made and no treatment has been received, if the nature of the disease is such as to presumptively indicate that it had its beginning before the effective date of the agreement, the waiting period will be applied.

Worsening of a pre-existing condition or complications arising in connection with it do not remove the waiting period requirement.

Any one of the following conditions without definitive history to the contrary will be considered to have been pre-existing: warts, moles, nevi, skin blemishes, scars, hemangioma, lymphangioma, superficial cysts, lipoma, peptic ulcer, gall stones, chronic cholecystitis, kindey stones, fibroid tumors of the uterus, retroversion and prolapse of the uterus, cystocele, rectocele, urethrocele, perineal laceration, ovarian cysts, congenital defects, deformities and anomalies, allergies, asthma, arthritis, tuberculosis, diabetes, hay fever, neoplasms, chronic appendicitis, deviation of nasal septum, valvular heart disease, vascular disease, varicose veins, hypertension, prostatitis, prostatism, prostatic obstruction, toxic goiter and myxedema.

The Blue Shield Subscription Agreement has both a general protective paragraph against pre-existing conditions, similar to that in the Blue Cross contract, and also spells out in detail certain surgical conditions which by designation require a waiting period of one year.

Exceptions to exclusion of pre-existing conditions cannot be made without endangering the financial stability of the Plans. In most instances, their treatment is elective and can be safely postponed until the waiting period has expired.

J. D. Guess

The Journal of the South Carolina Medical Association

Forty Years Ago

SEPTEMBER 1914

A vital statistics law had finally been passed, after continued efforts of the South Carolina Medical Association since 1848! Announcement of the approaching opening of the new Medical College building was made. A paper propounded the bacterial origin of pellagra. The Journal refused unethical advertisements. The Health Department obtained from the legislature a sum of $10,000 for establishing a sanatorium for tuberculous patients.

CORRESPONDENCE

Hartsville, South Carolina
August 23, 1954

The Editor
Journal of the South Carolina Medical Association

Dear Sir:

The work of the Crippled Children Society of South Carolina and its County Chapters has been planned and conducted throughout the state with the advice and counsel of the Medical Profession. The State Medical Advisory Committee advises the Society on programs and policies affecting the State as a whole, and County Medical Advisory Committees advise County Chapters on particular projects and programs in the larger counties. In the smaller counties, the advisory service of the doctors is informal but nonetheless valuable and helpful.

The cooperation and interest of State and County Medical Societies in the work of the Crippled Children Society of South Carolina and its County Chapters have been almost 100 per cent throughout the State. There is recognition on all sides of a common objective of helping crippled children and that such help, to be effective, must stem from professional diagnosis and treatment. The Crippled Children Society of South Carolina and its entire membership throughout the State are grateful to the Medical Pro-

fession for the priceless help and interest of the doctors throughout the State in the work of the Society.

The Crippled Children Society of South Carolina has suddenly become confronted with what appears to be a serious threat to its program of expanding service to crippled children in this state. Five years ago, the Society undertook the additional responsibility of serving, among others, the cerebral palsied. Clinics and treatment centers were set up and are being maintained throughout the State with the cooperation of the doctors and numerous service organizations. Plans are under consideration for further expansion of these services.

The policy of the Society has been to raise its funds primarily from an Easter Seal Sale Campaign once a year. This campaign is conducted largely by volunteer workers and through the cooperation of many service organizations. 91.2 per cent of the funds raised remain in the state, 8.8 per cent being devoted to crippled children work on a National level. The cost of raising funds for the crippled children work in this state, including supplies, stamps, etc., is about the lowest of any fund-raising campaign for any health program, because the work is done largely by volunteers without compensation. The total budget for the State Society and all local County Chapters, including the amount contributed to the National organization for the current year is $132,000. While this amount is comparatively small, very little of it goes to administrative expenses, the preponderant proportion being used to provide direct services and help to crippled children.

Now suddenly comes into South Carolina an organization under the name of United Cerebral Palsy Associations, Inc., which has expanded rapidly throughout the United States in the five years since it was set up, with the announced intention of organizing local affiliates in every county of 50,000 population or more. United Cerebral Palsy, as the name implies, is devoted primarily to serving the cerebral palsied. The organization is under able leadership, it has a program of large and fast expansion, its services in the field of cerebral palsy are worthy and in particular its substantial research program into the causes, treatment and prevention of cerebral palsy. The UCP has received National recognition. It conducts no annual money-raising campaign but carries on from time to time in different communities money-raising efforts, some of which are of a spectacular nature. Of all the funds raised, one-fourth goes to National Headquarters in New York. Of this 25 per cent, about 6 per cent is used for research.

The UCP organization came into this state by setting up a telethon money-raising project in Greenville, which the organization reported to have raised a gross amount of $70,000. This money-raising project was largely a professional one, and there has been no public report as to the cost and expenses of raising this amount. Efforts are now being made to set up affiliates in Spartanburg, Columbia, Charleston and four or five other cities throughout the state.

The concern of the Crippled Children Society of South Carolina and the County Chapters, as well as other volunteer organizations that are helping in the work with the cerebral palsied, arises from the facts that:

(1) Duplication of money-raising efforts in this State to serve the needs of the cerebral palsied and other crippled children will cause confusion to the public and possibly some irritation over multiple demands for funds for the same type of service;

(2) The United Cerebral Palsy Organization has come into South Carolina and is setting up affiliates that are not in response to any request on the part of the people of the State for additional and unmet services not now being rendered by the Crippled Children Societies;

(3) The UCP undertook its organizational program in this state without any survey as to what the needs of the cerebral palsied might be or as to the services being rendered by the Crippled Children Societies and other organizations to the cerebral palsied and without any consultation or conference with officers or staff of the Crippled Children Society of South Carolina. It was only after repeated efforts on the part of the officers of the Crippled Children Society to find out what the purpose and program of UCP was in South Carolina and after the UCP found it difficult to organize local affiliates that representatives of UCP conferred with the officers of the Crippled Children Society.

The dilemma in which the Crippled Children Society of South Carolina and its County Chapters find themselves is that they do not want to be put in a position of opposing a Nationally recognized organization that is devoted to the service of the cerebral palsied when such service is one of the major concerns of the Crippled Children Society. On the other hand, it is generally felt that there is no need for two organizations throughout the state serving to a large extent the same field of service with resulting duplications, complications, etc. The UCP insists that it does not want the Crippled Children Society to retire from its service to the cerebral palsied but on the other hand desires to avoid any duplication of effort. The position of the Crippled Children Society of South Carolina is that no additional organization is required to serve the needs of the cerebral palsied and that if the people of the State desire and are willing to pay for increased services to the cerebral palsied, the Crippled Children Society will increase its activities and services. The Society is confident that it can raise additional funds as effectively and with as great or greater economy as the UCP.

The final determination of the policy to be followed by the Crippled Children Society will rest primarily in the hands of the doctors throughout the State. Neither organization can operate effectively without the cooperation and help of the Medical Profession. The Crippled Children Society will be guided in a large measure by the advice and counsel of the Medical Profession, speaking through its local and state organizations and in particular through State and local

Medical Advisory Boards of State and County Crippled Children Societies.

Let it be clearly understood that on the part of the Crippled Children Society there is no "professional jealousy" or organizational competition involved in the question of the UCP entering this State and setting up money-raising and service affiliates in the field of cerebral palsy. The money to finance both organizations will come from the people of South Carolina. It, therefore, becomes primarily a question of whether the people of the state desire to finance two organizations serving largely the same needs. If so, the question then becomes one of how the two organizations can work in the same field of service without duplication of effort and services and with a minimum toll against the contributor's dollar for expenses and with maximum benefits to the cerebral palsied in this state.

The doctors are better qualified than anyone else in South Carolina to give the proper answers to these questions. The Crippled Children Society of South Carolina will welcome the guidance of the Medical Profession.

Sincerely,
A. L. M. Wiggins, President
Crippled Children Society
of South Carolina

NEWS

Dr. Jack A. Thurmond recently completed his internship at General Hospital, Greenville, and is now associated in general practice with Dr. A. D. Couch in the McCravy Building on Pendleton St.

Dr. A. W. Lowman, Denmark physician, was installed as persident of the Denmark Lions club at the regular meeting of the club on July 8.

Dr. Michael C. Watson, who was graduated in 1952 from the South Carolina Medical College, moved to Bamberg and has established an office on Bridge Street in the building used by the late Dr. T. M. Stuckey.

Dr. Frank F. Espey has opened offices at 123 Mallard St. for the practice of neurosurgery. He is the first specialist in that field to locate in Greenville.

Dr. B. Lewis Barnett of Woodruff discontinued his practice in the Anderson Building on July 22, for an extended tour with the U. S. Navy. He reported for temporary duty at the U. S. Naval Hospital in Charleston on August 2.

Dr. James MacDonald arrived recently to begin practice at Joanna.

Dr. Max A. Culp, native of Edgemoor has opened his office for the general practice of medicine at 132 Confederate St., Fort Mill.

Joanna Memorial Hospital marked its fifth anniversary with more than 125 persons attending a barbecue dinner at Joanna Club House and a tour of the hospital.

The 14-bed hospital facilities include an operating room, X-ray room, laboratory and complete obstetrical department. The hospital, representing an investment of more than $150,000, was erected as an employee-employer projects by voluntary contributions from Joanna employees and a generous gift from the late William H. Regnery of Chicago.

Norton L. Williams, M. D. has opened an office for the practice of Psychiatry and Psychoanalysis at 164 Wentworth Street, Charleston.

Dr. Rhett Talbert will teach in the neurology department at the Medical College and will also engage in private practice and consultation. He has completed work in neurology at Massachusetts General Hospital in Boston and at Richmond.

Dr. Charles R. Propst has opened an office for the practice of pediatrics in Sumter.

The thriving Joanna Cotton Mills community now has two private practitioners to serve the medical needs of the people of that area.

Dr. James Macdonald recently moved there with his family and began practice on July 15 with his office located on Joanna Square at the entrance of the mill.

Dr. D. H. McFadden, whose residence is on Milton Road, began the practice of medicine at Joanna in 1941.

Dr. James Pierce Horton, Jr., and Dr. William Elford Sims, Jr., have announced the opening of their offices in the building formerly occupied by the Lancaster Telephone Company for the general practice of medicine in Lancaster.

Dr. Emory L. Langdale began the practice of medicine in Walterboro on July 12. He is associated with Dr. Marshall Bennett.

Dr. George Soloyanis became South Carolina's first director of community services with the State Mental Health Commission July 1.

For the past year, he has been clinical psychologist with the Greenville Mental Hygiene Clinic.

Dr. H. LeRoy Brockman, a nephew of Dr. W. Thomas Brockman of Greenville, opened offices for the practice of surgery in Greer about July 1.

Dr. Hugh H. DuBose of 308 Fulton Street has opened an office at 1515 Bull St. where he will practice internal medicine in Columbia.

Dr. C. M. Lide has taken a position with the Veterans Administration and has closed his office in Florence.

Dr. J. Heyward Gibbes has announced the association of Dr. James C. Vardell, Jr. in the practice of internal medicine at 1417 Hampton Street, Columbia, S. C.

Give the United Way!

PRESIDENT'S NOTES

All of you are probably aware of the fact that the Naturopaths have entered suit in the courts asking clarification of the Naturopathy laws of this state. Evidently, the intent is to make legal the prescribing of narcotics by that sect. Our executive secretary, Mr. Meadors, is joining with the Attorney General in answer to the suit and will keep us informed as to the outcome.

Though the legislature is not immediately concerned in this present suit, I believe it would be wise for each of us to let our legislators and senators know something of the character and type of training given to Naturopaths in order that they might be better qualified to pass upon any legislation which should come before them regarding this sect.

TOM GAINES

(Cont'd. from page 272)

COMMITTEE ON RURAL HEALTH:
Dr. W. W. Pressly, Chairman ---------- Due West
Dr. C. R. F. Baker ---------- Sumter
Dr. Ned Camp ---------- Anderson

COMMITTEE ON INDIGENT CARE:
Dr. William S. Brockington, Chairman --- Greenwood
Dr. Henry F. Hall ---------- Columbia
Dr. Roderick MacDonald ---------- Rock Hill
Mr. M. L. Meadors, ex-officio ---------- Florence

ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY:
Dr. O. B. Mayer, Chairman ---------- Columbia
Dr. George Blalock ---------- Clinton
Dr. John Buchanan ---------- Winnsboro
Dr. J. A. Siegling ---------- Charleston
Dr. Carl West ---------- Camden
Mr. M. L. Meadors ---------- Florence

MEDICAL ADVISORY BOARD TO THE CRIPPLED CHILDREN'S SOCIETY OF SOUTH CAROLINA:
Dr. Joseph I. Waring, Chairman ---------- Charleston
Dr. William Weston, Jr., Vice-Chairman --- Columbia
Dr. John Bell ---------- Greenwood
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Dr. William R. DeLoach ---------- Greenville
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Dr. Frederick E. Kredel ---------- Charleston
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Dr. W. O. Whetsell ---------- Orangeburg
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COMMITTEE ON CONVENTION CRUISE:
Dr. Harry A. Davis, Jr., Chairman ---------- Sumter
Dr. Richard W. Hanckel ---------- Charleston
Dr. R. Murdock Walker ---------- Sumter

COMMITTEE ON INDUSTRIAL HEALTH:
Dr. W. W. Edwards, Chairman, Surgery --- Greenville
Dr. James L. Hughes, G. P. ---------- Greer
Dr. Edward M. Gunn, Occ. Med. ---------- Hartsville
Dr. Izard Josey, Int. Med. ---------- Columbia
Dr. Frank Stelling, Orthopedics ---------- Greenville
Dr. David S. Asbill, Ophthalmology ---------- Columbia
Dr. Clay W. Evatt, Otolaryngology ---------- Charleston
Dr. J. W. Wyman, Dermatology ---------- Anderson
Dr. Katherine MacInniss, Allergy ---------- Columbia
Dr. Samuel Fisher, Radiology ---------- Greenville
Dr. William P. Beckman, Psychiatry ---------- Columbia
Dr. Manley Hutchinson, Gyn. ---------- Columbia

COMMITTEE ON MEDICAL EDUCATION:
Dr. John T. Cuttino, Chairman ---------- Charleston
Dr. J. Decherd Guess ---------- Greenville
Dr. Pierre Jenkins ---------- Charleston

COMMITTEE ON THE CARE OF THE PATIENT:
Dr. Walter Mead ---------- Florence
Dr. J. K. Webb ---------- Greenville
Dr. C. R. May ---------- Bennettsville
Dr. W. T. Hendrix ---------- Spartanburg
Dr. Henry Robertson ---------- Charleston

ANNOUNCEMENTS

SOUTH CAROLINA ACADEMY OF GENERAL PRACTICE

I would like to take this opportunity to extend an invitation to every practicing physician in South Carolina to attend the Sixth Annual Scientific Assembly of the South Carolina Academy of General Practice to be held in Columbia at the Columbia Hotel on September 28 and 29, 1954.

We feel that an excellent program has been arranged; one that will be of interest to all, but of particular value to the general practitioner. It is highlighted by the appearance of Dr. Russel L. Cecil, Professor of Clinical Medicine, Emeritus, Cornell, University, New York; as well as Dr. Philip A. Mulherin, Professor of Pediatrics, University of Georgia Medical School, Augusta, Georgia, and many of the outstanding members of the faculty in Charleston.

The program follows:

SIXTH ANNUAL
SCIENTIFIC ASSEMBLY
OF
SOUTH CAROLINA ACADEMY OF
GENERAL PRACTICE
COLUMBIA HOTEL, COLUMBIA, S. C.
September 28 and 29, 1954

PROGRAM

Tuesday, September 28, 1954

8:30 a. m. Registration
9:20 a. m. Welcome—Dr. David F. Adcock
President Columbia Medical Society
9:30 a. m. "Care of the Premature Infant"
Dr. Philip Mulherin
Professor Pediatrics, University of Georgia Medical School, Augusta, Georgia
10:10 a. m. "Arthritis" Dr. Russel L. Cecil
Professor of Clinical Medicine Emeritus, Cornell University, New York
11:20 a. m. "The Diagnosis of Cervical Carcinoma"
Dr. Lawrence L. Hester, Jr.
Assistant Professor of Obstetrics and Gynecology, Medical College of South Carolina, Charleston, S. C.
1:00 p. m. Luncheon—
Speaker—Dr. John R. Bender, Winston Salem, N. C. Vice president Elect, American Academy of General Practice
3:00 p. m. "Antibiotic Antagonism and Synergism"
Dr. Charlton deSaussure, Department Medicine, Medical College of South Carolina, Charleston, S. C.
3:50 p. m. Panel Discussion:
"Hemorrhage in Late Pregnancy"
Moderator—Dr. Lawrence L. Hester
Discussants:
Dr. T. G. Herbert, Jr.
Dr. G. F. Wilson
Dr. W. C. Finger
Dr. J. R. Sosnowski
Associate Professors of Obstetrics and Gynecology, Medical College of South Carolina, Charleston, S. C.
7:00 p. m. Refreshments
8:00 p. m. Banquet—Speaker: Dr. W. B. Hildebrand, Menasha, Wisconsin,
President American Academy of General Practice

Wednesday, September 29, 1954

8:30 a. m. Registration
9:30 a. m. "The Allergic Child"—Dr. Philip Mulherin
10:20 a. m. "Cortisone and ACTH in Infectious Diseases"
Dr. Charlton deSaussure
11:15 a. m. "Gout"—Dr. Russel L. Cecil
1:00 p. m. Luncheon—
Speaker: Dr. Thomas R. Gaines, Anderson, S. C.
President South Carolina Medical Association
2:45 p. m. Round Table Discussion:
Moderator: Dr. John T. Cuttino, Dean Medical College of South Carolina, Charleston, S. C. Participants: all visiting lecturers
4:00 p. m. Business Meeting
Adjournment

I hope that it will be my pleasure to see many of you in Columbia September 28 and 29.

Sincerely,
W. Wyman King, President
South Carolina Academy of General Practice

CLINICAL FELLOWSHIPS OF THE AMERICAN CANCER SOCIETY

A limited number of Fellowships offer graduates in medicine opportunities for postgraduate training, emphasizing diagnosis and treatment of cancer.

Fellowships available on and after July 1, 1955 will be awarded for one year and are renewable to and including three years.

Fellowships are awarded to *institutions* only upon applications by deans, executive officers or department heads.

Individuals desiring such Fellowships should consult the appropriate authority in the institution of their choice.

Applications for Fellowships for the year 1955-56 must be submitted prior to September 15, 1954.

Further information may be obtained from:

AMERICAN CANCER SOCIETY
PROFESSIONAL EDUCATION SECTION
47 Beaver Street
New York 4, N. Y.

The South Carolina Chapter of the American College of Surgeons plans a meeting at the Columbia Hotel in Columbia, S. C. on October 29th and 30th. This meeting is not exclusively for the members of the College of Surgeons.

There will be several very outstanding guest speakers such as, Dr. John Adams of Boston; Dr. Bradley Coley, Cancer Authority, Memorial Hospital, New York; Dr. Don Russell, President, University of South Carolina; Dr. William Rienhoff, Johns Hopkins; Dr. Alton Ochsner of New Orlenas or others.

Sectional meetings and seminars will be planned in addition to the General Assembly meeting.

There will be a banquet and dance on the evening of October 29. The Scientific Session will terminate Saturday noon in time for all to occupy a special section on the 50-yard line at the Carolina-Maryland football game.

Registration will start early Friday morning, October 29th.

Reservations for football tickets and for the dining room should be made with Dr. John R. Timmons, 1401 Taylor Street, Columbia, S. C.

SOUTH CAROLINA SOCIETY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY

A joint meeting of the North Carolina Eye, Ear, Nose, and Throat Society and the South Carolina Society of Ophthalmology and Otolaryngology will be held at Durham, N. C., November 4, 5, and 6, 1954. Headquarters will be the Washington Duke Hotel.

Guest otolaryngologists will be Dr. Stanton A. Friedberg of Chicago, Dr. John Maxwell of Ann Arbor, and Dr. George Baylin of Durham. The following guest ophthalmologists will likewise be on the program: Dr. Charles Iliff of Baltimore, Dr. John McLean of New York, and Dr. Townley Paton of New York.

On Wednesday preceding the beginning of the meeting, operative clinics will be held in the various hospitals of Durham and Chapel Hill.

Finally, there will be a football game on Saturday afternooon between the University of North Carolina and the University of South Carolina in Chapel Hill.

The 1954 Annual Convention of the National Society for Crippled Children and Adults will be held Nov. 3-5, 1954, at the Hotel Statler, Boston, Mass.

TENNESSEE VALLEY MEDICAL ASSEMBLY

(Sponsored by the Chattanooga and Hamilton County Medical Society)

READ HOUSE, CHATTANOOGA, TENNESSEE

Will Be Held On

Monday, September 27, and Tuesday, September 28, 1954

Registration fee is $15, and includes the banquet on Monday night. Early registration is urged and should be sent to Robert C. Hart, Executive Secretary, 108 Medical Arts Building, Chattanooga, Tennessee.

The 37th Annual Conference of the American Occupational Therapy Association will be held at the Shoreham Hotel, Washington, D. C., October 16-22, 1954. The meetings will be as follows:

October 16-17—Preliminary Meetings.

October 18-19—Institute—International Relations.

October 20-21-22—General Conference—Theme: "Capitalize Your Assets"

INTERNATIONAL ACADEMY OF PROCTOLOGY

1954-1955 AWARD CONTEST

The International Academy of Proctology announces its Annual Cash Prize and Certificate of Merit Award Contest for 1954-1955. The best unpublished contribution on Proctology or allied subjects will be awarded $100.00 and a Certificate of Merit. Certificates will be awarded also to physicians whose entries are deemed of unusual merit. This competition is open to all physicians in all countries, whether or not affiliated with the International Academy of Proctology. The winning contributions will be selected by a board of impartial judges, and all decisions are final.

The formal award of the First Prize, and a presentation of other Certificates, will be made at the annual Convention Dinner Dance of the International Academy of Proctology, in March 1955. The International Academy of Proctology reserves the exclusive right to publish all contributions in its official publication, "The American Journal of Proctology". All entries are limited to 5,000 words, must be typewritten in English, and submitted in five copies. All entries must be received no later than the first day of February, 1955. Entries should be addressed to the International Academy of Proctology, 43-55 Kissena Boulevard, Flushing, New York.

SOUTHERN MERICAL ASSOCIATION

Forty-Eighth Annual Meeting

Keil Municipal Auditorium

ST. LOUIS, MISSOURI

November 8, 9, 10 and 11, 1954

Registration, Scientific and Technical Exhibits, and Section Meetings in Keil Municipal Auditorium

All Activities Under One Roof

AMERICAN MEDICAL WRITERS' ASSOCIATION MEETING, CHICAGO, SEPT. 24

The 11th Annual Meeting of the American Medical Writers' Association will be held at the New Hotel Sherman, Chicago, Friday, Sept. 24. This is the Association's first Chicago meeting and an unusual, full day program, comprising 17 speakers, has been arranged. The morning program is a symposium and panel concerning the new 4 year courses of medical journalism and writing to be given at the University of Illinois and University of Missouri.

To increase the number of well-trained teachers in the field of preventive medicine, the National Foundation for Infantile Paralysis is now offering a limited number of senior fellowships to physicians interested in study and research in the teaching of preventive medicine. This is a new effort to bring support to this field.

The program of study may be undertaken at an approved school of public health or in a department of preventive medicine of an approved medical school.

Fellowships will be awarded for one or more years, with stipends ranging from $4,500 to $7,000 a year, depending upon marital status and number of dependents.

For further information address the National Foundation for Infantile Paralysis, Division of Professional Education, 120 Broadway, New York 5, N. Y.

AMERICAN COLLEGE OF PHYSICIANS TO USE NATIONWIDE TV CLOSED CIRCUIT TELECAST IN CONNECTION WITH ITS POSTGRADUATE PROGRAM

On Thursday evening, September 23, 1954, from 6:00 P. M. to 7:00 P. M., Eastern Daylight Saving Time, the American College of Physicians will utilize television through a national closed circuit over the Columbia Broadcasting System to carry to its members and their colleagues a SYMPOSIUM ON THE MANAGEMENT OF HYPERTENSION. This telecast is made possible through the co-operation and generous support of Wyeth Incorporated of Philadelphia, and will be the *first nationwide* closed circuit hookup for postgraduate medical education.

The panel of distinguished physicians who will participate includes:

Cyrus C. Sturgis, M.D., F.A.C.P., Presiding
President, American College of Physicians
Professor of Internal Medicine
University of Michigan, Ann Arbor

F. H. Smirk, M.D., F.R.A.C.P.
Professor of Medicine, University of Otago
Dunedin, New Zealand

Garfield G. Duncan, M.D., F.A.C.P.
Director of the Medical Division
Pennsylvania Hospital, Philadelphia

R. W. Wilkins, M.D., F.A.C.P.
Chief, Hypertension Clinic
Massachusetts Memorial Hospital, Boston

Edward D. Freis, M.D. (Associate)
Adjunct Clinical Professor of Medicine
Georgetown University, Washington

Professor Smirk is one of the topmost authorities of the world on methonium compounds. He went to New Zealand from England in 1940 to take the Chair of Medicine at the University of Otago. He is a Fellow of the Royal College of Physicians of London and of the Royal Australasian College of Physicians, being the Senior Censor for the latter in New Zealand. He appears on this program as an official representative of the Royal Australasian College of Physicians in connection with an exchange-guest program being arranged between the two Colleges.

A "closed TV circuit" is one by which reception is controlled and not open to the general TV public. This telecast cannot be picked up in the home, but the invited audience must go to the TV receiving station. Twenty-three such receiving stations will be used; these will be located in Boston, New York, Philadelphia, Washington, Pittsburgh, Charlotte, Atlanta, Cincinnati Detroit Chicago, St. Louis, Milwaukee, Minneapolis, Memphis, Dallas, Houston, New Orleans, Denver, Salt Lake City, Los Angeles, San Francisco, Baltimore and Cleveland.

DEATHS

DR. J. P. STUKES, SR.

Dr. J. P. Stukes, Sr., 77, member of an old South Carolina family noted for its doctors and judges, died at his home at Macon, Ga., July 4.

DR. D. T. TEAL

Dr. D. T. Teal, 83, senior physician of Chesterfield County, died at his home July 29 after completing 60 years active practice of medicine.

SOUTH CAROLINIANA

Abstacts by Dr. Manly Stallworth

Prioleau, Wm. H., Stallworth, J. M.

Gaseous Distention of the Gastrointestinal Tract — Its Significance, Prevention and Treatment. (American Surgeon 19:418, May 1953)

Gaseous distention of the G.I. tract should be prevented if possible and when present, every effort should be directed toward its relief. Swallowed and ingested air is the predominant factor in bowel distention. This can be prevented and treated by suction intubation of the stomach and intestines, and by enterostomy. Enemas and drugs are of little value and at times harmful. Compromise of the blood supply must not be overlooked.

Prioleau, Wm. H., Stallworth, J. M.

The Supportive Boot for Chronic Venostasis, G.P. 9:47, March 1954.

A suitable and adequate support to the venous return is essential to the satisfactory treatment of most cases of chronic venostasis. It is of value as a diagnostic measure, in preparing the patient for operation, and for long continued palliation. A combination of Unna's paste and elastic adhesive has proven satisfactory in most cases. The pulsatile air-pressure boot is particularly suitable for long continued use.

Wallace, F. T., Wilson, R. S., Thompson, W., (Spartanburg)

Prolapse of the rectum in children. (Tri-State Med. j. 1:11-12, Sept. 1953).

A method of direct linear cauterization to the rectum extending from the ano-rectal junction for about 3 inches proximally into the rectum, performed to promote scarring and fixation in an effort to prevent recurrent prolapse of the rectum in children, is presented. The authors reported no permanent recurrences of the prolapse of the rectum.

Webb, J. K. (Greenville)

Adrenalectomy in recurrent breast cancer. (Tri-state med. j. 1:12-14, Sept. 1953).

The case of a 65 year old woman who had recurrent metastatic carcinoma following breast amputation and irradiation, done 18 months previously is presented. Additional x-ray and testosterone gave only temporary improvement. Bilateral adrenalectomy and oophorectomy resulted in regression of the size of the metastatic lesion, and a sense of well being in the patient.

Parker, E. F. (Charleston)

The early diagnosis of carcinoma of the esophagus. (Am. Surgeon 20:424-434, April 1954).

In order to ascertain the reasons for delayed diagnosis, the author reviewed the records of 187 cases of epidermoid carcinoma of the esophagus. He lists the commonly associated symptoms, the causes for erroneous diagnoses, and emphasizes these points, utilizing case histories. The value of esophagograms in the absence of fluoroscopic finding, and repeated esophagoscopic examinations are stressed in the study of patients with possible carcinoma.

Wilson, R. S., Wallace, F. T., Whiting, J. A. & Poole, C. H. (Spartanburg)

Technical aid in esophageal diverticulectomy. (J. of intern. college surg. 20:192-195, August 1953).

A case study is presented of a 55 year old woman with an esophageal diverticulum, which was treated by one stage excision utilizing a flexible Cameron type of light inserted into the pouch by the transoral route in order to visualize the diverticulum during the operative excision. The wound healed uneventfully and the patient was discharged from the hospital 14 days after operation, without symptoms.

Corbett, W. M. & Fellers, F. H. (Columbia)

Traumatic liver abscess. (Tri-state M. J. 1:11-12, Jan. 1954).

After a review of the incidence, pathology, symptoms, prognosis, and treatment of trauma to the liver and secondary abscesses, the authors present the case of a 34 year old man who sustained a blow to the upper abdomen followed by the formation of a sterile abscess which was drained anteriorly about 5 weeks after the accident, resulting in complete recovery of the patient.

Dramamine's® Effect in Vertigo

Dramamine has become accepted in the control of a variety of clinical conditions characterized by vertigo and is recognized as a standard for the management of motion sickness.

Vertigo, according to Swartout, is primarily due* to a disturbance of those organs of the body that are responsible for body balance. When the posture of the head is changed, the gelatinous substance in the semi-circular canals begins to flow. This flow initiates neural impulses which are transmitted to the vestibular nuclei. From this point impulses are sent to different parts of the body to cause the symptom complex of vertigo.

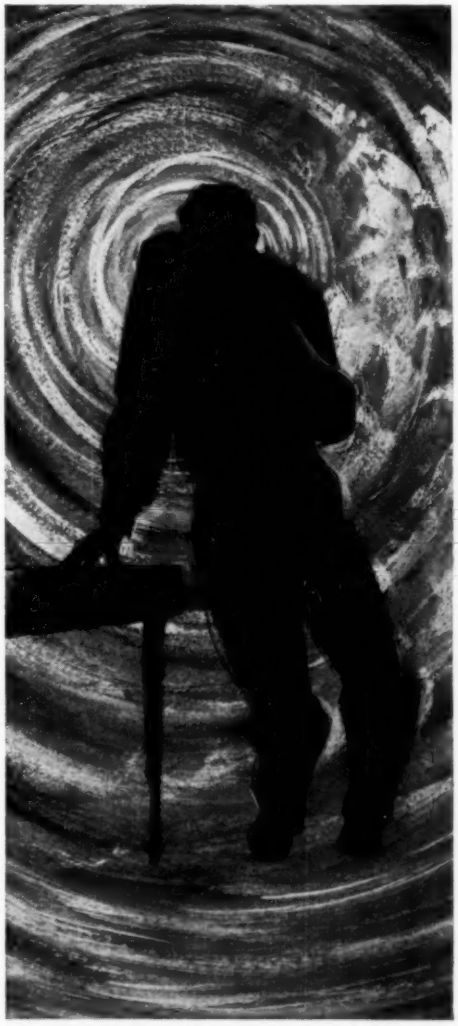
Some impulses reach the eye muscles and cause nystagmus; some reach the cerebellum and skeletal muscles and righting of the head results; others activate the emetic center to result in nausea, while still others reach the cerebrum making the person aware of his disturbed equilibrium. *Vertigo may be caused by a disease or abnormal stimuli of any of these tissues involved in the transmission of the vertigo impulse, including the cerebellum and the end organs.*

A possible explanation of Dramamine's action is that it depresses the overstimulated labyrinthine structure of the inner ear. Depression, therefore, takes place at the point at which these impulses, causing vertigo, nausea and similar disturbances, originate. Some investigators have suggested that Dramamine may have an additional sedative effect on the central nervous system.

Repeated clinical studies have established Dramamine as valuable in the control of the symptoms of Ménière's syndrome, the nausea and vomiting of pregnancy, radiation sickness, hypertension vertigo, the vertigo of fenestration procedures, labyrinthitis and vestibular dysfunction associated with antibiotic therapy, as well as in motion sickness.

Any of these conditions in which Dramamine is effective may be classed as "disease or abnormal stimuli"* of the tissues including the end organs (gastrointestinal tract, eyes) and their nerve pathways to the labyrinth.

Dramamine (brand of dimenhydrinate) is supplied in tablets of 50 mg. and liquid (12.5 mg. in each 4 cc.). It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.



The site of Dramamine's action is probably in the labyrinthine structure.

*Swartout, R., III, and Gunther, K.: "Dizziness:" Vertigo and Syncope, GP *8*:35 (Nov.) 1953.

BOOK REVIEW

EMERGENCY TREATMENT AND MANAGEMENT, by Thos Flint, Jr. W. B. Saunders, Philadelphia, 1954. Price $5.75.

This book is writen for the "Emergency Physician," whether he functions in a hospital emergency room or in his own office. It contains a lengthy and detailed compilation of the innumerable conditions which may suddenly and imperatively confront any practitioner. In this respect it should be as valuable as it is inclusive. Its cross references are handy and its presentations are complete but succinct. In reviewing a books such as this the temptation to sample the items with which one is more likely to be familiar is irrestible. Thus opinion may differ or carry a certain bias. Be that as it may we must necessarily lift an eyebrow at a number of minor points, such as the definite admonition to limit barbiturate prescriptions to only a few doses, the unmodified recommendation of arbitrary fractional doses for children, the use of trade names for official drugs. We wonder why simple blepharitis and conjunctivitis must be referred to an ophthalmologist, and why the capable physician of the emergency room should not be fit to open a bulging eardrum (surely a pediatric emergency). Why saline solution for acidosis when others might be better? Why speak of the drastic results of ingestion of kerosene when aspiration is the important factor? And why use Brown Mixture, and worse, why call it "Brown's Mixture"?

But all of these are relatively minor matters, and if the reader differs in details, he can make his own corrections. As an "Emergency Physician", he would be glad to have this book nearby.

J. I. W.

AT THIS VERY MOMENT

At this very moment more than two million men and women, and boys and girls too, are mobilizing all over the nation for this year's greatest voluntary fund raising effort.

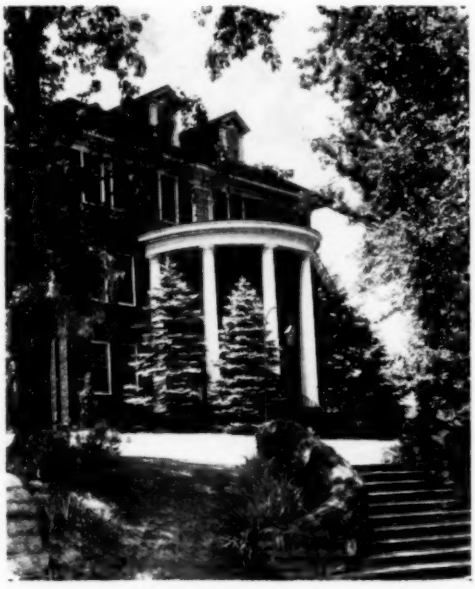
Working together to provide operating funds for almost 20,000 health, recreation, family welfare and defense related services, these volunteers must raise $290,000,000 . . . the millions of dollars needed to help keep millions of people healthy in mind, in body and in spirit.

When your community volunteer calls on you for your once-a-year contribution to your town's Community Chest, United Fund or Red Feather campaign, he brings you an opportunity to give your support to many appeals at one time.

Remember to give generously . . . the united way.

HIGHLAND HOSPITAL, INC.

FOUNDED IN 1904
ASHEVILLE, NORTH CAROLINA



Affiliated with Duke University.

A non-profit psychiatric institution, offering modern diagnostic and treatment procedures — insulin, electroshock, psychotherapy, occupational and recreational therapy — for nervous and mental disorders.

The Hospital is located in a 75 acre park, amid the scenic beauties of the Smoky Mountain Range of Western North Carolina, affording exceptional opportunity for physical and nervous rehabilitation.

The OUT-PATIENT CLINIC offers diagnostic services and therapeutic treatment for selected cases desiring non-resident care.

R. Charman Carroll, M.D., Diplomate in Psychiatry. — Medical Director.

Robt. L. Craig, M. D., Diplomate in Neurology & Psychiatry, Associate Medical Director.

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WOMAN'S AUXILIARY
SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. A. T. Moore, Columbia, S. C. **Publicity Secretary: Mrs. N. D. Ellis, Florence, S. C.**

SOUTHERN MEDICAL AUXILIARY WHAT IS THE SOUTHERN AUXILIARY AND WHY WAS IT ORGANIZED?

The Southern Medical Auxiliary is comprised of the wives of doctors who are members of the Southern Medical Association. There are no dues in the auxiliary; wives automatically become members of the auxiliary when their husbands join the Association whose dues are $10.00 per year which includes the very wonderful Southern Medical Journal published monthly; and there is NO REGISTRATION FEE AT CONVENTION. The Association was organized in 1906 in Chattanooga, Tennessee, for the primary purpose of studying more intimately the problems of Southern medicine and diseases peculiar to the southern states, the results of this research and clinical experience to be shared with the world. It is the second largest general medical association in the country and now in its 48th year.

The Woman's Auxiliary to the Southern Medical Association was organized in New Orleans, La., November 25, 1924 by a group of wives who attended the meeting with their husbands, for the purpose of promoting friendliness and good fellowship among physicians and their families. The Association each year appropriates sufficient money for our expenses.

WHAT IS THE JANE TODD CRAWFORD MEMORIAL STUDENT LOAN FUND?

This fund was created in 1928 to honor the memory of that courageous Kentucky pioneer woman who submitted to the first ovarian operation without benefit of anesthesia, which was performed by Dr. Ephraim McDowell in Danville, Ky., on Christmas Day, 1809. This fund is voluntarily contributed to by counties in the Southern States, which money is loaned at 3% interest rate to any student or doctor who can qualify to further his knowledge in the study of gynecology.

WHAT IS RESEARCH AND ROMANCE OF MEDICINE?

This project was adopted in 1930 to preserve the medical history of the south with biographies of doctors; histories of medical societies and auxiliaries and their projects; nurses and others who have contributed to the progress of medicine.

WHY IS DOCTOR'S DAY CELEBRATED?

In 1935, March 30th was designated as "DOCTOR'S DAY" by the Southern Auxiliary to honor members of the medical profession both living and dead, this date being selected because in 1942 Dr. Crawford Long of Georgia first successfully used anesthesia. In 1949 the red carnation was adopted as the official flower for Doctor's Day, and all Southern States observe the day in various ways.

ANNUAL CONVENTION

The Annual convention of the Woman's Auxiliary to the Southern Medical Association will be held in conjunction with the meeting of the Association in St. Louis, Missouri, Nov. 8-11, 1954. All Doctors and their wives in South Carolina are cordially invited to attend.

Mrs. Kirby D. Shealy
Councillor for South Carolina

MRS. ALFRED F. BURNSIDE ELECTED NATIONAL DIRECTOR

The Auxiliary to the South Carolina Medical Association is honored to have Mrs. Alfred F. Burnside of Columbia elected to the Board of Directors of the Auxiliary to the American Medical Association. Roberta has been a prominent figure in Auxiliary activities. She has served her local auxiliary in varied capacities, served as president of the Auxiliary to the South Carolina Medical Association, as program chairman of the national auxiliary and as a member last year of the nominating committee of the Auxiliary to the A. M. A. During the past year she served as Doctor's Day Chairman of the Auxiliary to the Southern Medical Association and is currently First Vice-President of the Southern Auxiliary. All this recognition has been justly deserved and to her new high position Roberta takes a wealth of experience in leadership and service in medical auxiliary work.

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